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The Ohio State Medical Journal

Vol. 50 January, 1954 No. 1

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $3.00 per year to non-members; Single Copy, 30 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to standards and regulations established by the American Medical Association.

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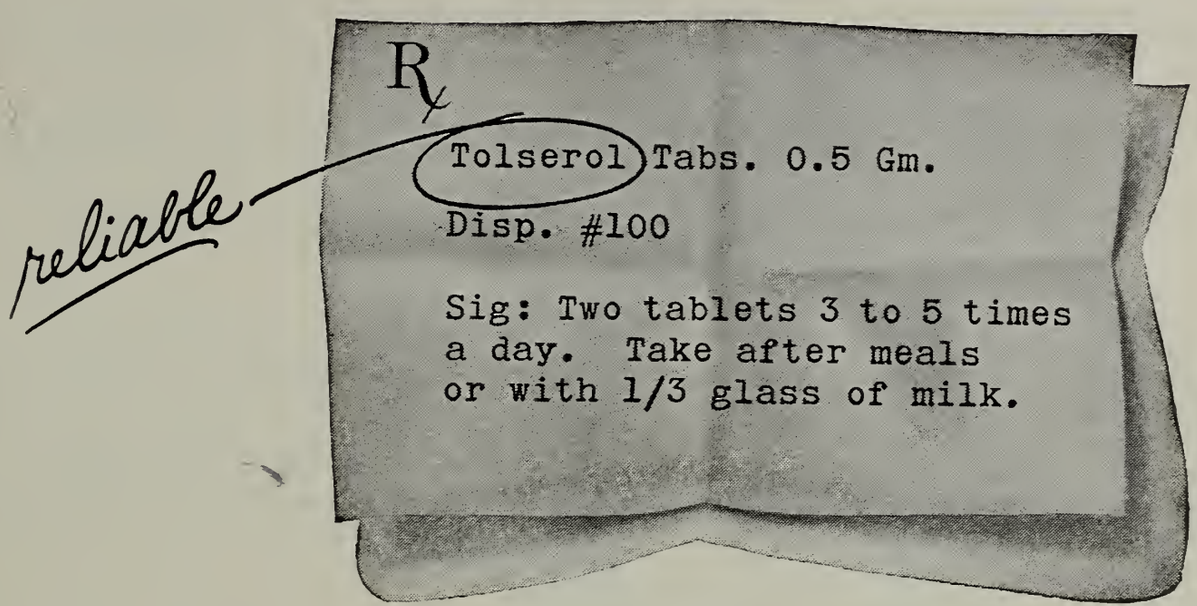
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Pathology in Surgery, by Edwin F. Hirsch, M. D., ($10.00. *Williams & Wilkins Company, Baltimore 2, Md.).* The pathologist to St. Luke's Hospital in Chicago presents his own experience in the examination of surgically removed tissue in terms of general and special pathology.

The Neurophysiological Basis of Mind, by John Carew Eccles, Professor of Physiology, The Australian National University, Canberra, ($6.50. *Oxford University Press, New York 11, N. Y.),* being the Wayneflete Lectures for 1952. The author attempts to see how far scientific investigation of the nervous system has helped in the understanding not only of the working of the brain, but also how liaison between mind and brain could occur.

Mr. Tompkins Learns The Facts of Life, by George Gamow, ($2.75. *Cambridge University Press, New York 22, N. Y.).* The hero of two earlier works now turns his attention to biology to give with plenty of good humor the facts of life—Genes, cell division, enzymology. He gets an answer to the broad question, "What is it that makes my multitude of cells me?" Finally, he hears a lecture by the Professor on the nature of our existence in which the present state of biological knowledge is summed up in terms that anyone can grasp. In all a very interesting and informative book.

Electronology, by David J. Calicchio, M. D,. ($2.00. *Meador Publishing Co., Boston 15, Mass.),* is one surgeon's answer to the question, "Are we the product of the Infinite Electronics?" The author attempts to peer into the minds of future scientists.

Your Health Handbook, by Julius B. Richmond, M. D., ($0.40. *Science Research Associates, 57 West Grand Street, Chicago 10, Ill.),* is a "Junior Life Adjusting Booklet" written for the boys and girls in the upper elementary and junior high schools. Your reviewer feels that these youngsters will read it.

Emotional Problems of Illness, by Irene M. Josselyn, M. D., ($0.40. *Science Research Associates, 57 West Grand Street, Chicago 10, Ill.),* is another "Junior Life Adjusting Booklet." With help the youngsters understand their illness. Being confined to bed is not such a pleasant experience for an active child and of itself creates emotional problems. This booklet is designed to reconcile him to his fate.

Care of The Back, by William K. Ishmael, M. D., and Howard B. Shorbe, M. D., (Apply for price in quantities. *J. B. Lippincott Company, Philadelphia, Pa., or J. W. Colen, 3750 Lake Shore Drive, Chicago 13, Ill.).* A manual designed for distribution by the physician to his patients. It points out the specific things that the average person does which result in fatigue and subsequent pain in the back.

Washing Our Water: Your Job and Mine, by Helen Beal Woodward, ($0.25. *Public Affairs Committee, Inc., 22 East 38th St., New York 16, N. Y.).* Public Affairs Pamphlet No. 193. An excellent, popular presentation of the problems of stream pollution.

Pulmonary Hyaline Membranes, A Report of the Fifth M. & R. Pediatric Research Conference, Waldo E. Nelson, M. D., Chairman, (Apply. *M. & R. Laboratories, Columbus, Ohio),* brings together the findings and problems of the current research on this most frequent factor in death of premature infants.

Transactions of The American College of Cardiology, Volume II, Edited by Bruno Kisch, M. D., ($5.00. *American College of Cardiology, 845 West End Avenue, New York 25, N. Y.).* Containing the papers presented at the first meeting of the College.

Das Buch der Talsuchen (Des Dernieres Nouvelles de Strasbourg), Die integrate Wahrbreit uber Carcin Samling der authentischen Dokumente.

Therapeutics in Internal Medicine, Edited by Franklin A. Kyser, M. D., ($15.00. Second Edition, Completely Revised. *Hoeber-Harper, New York 16, N. Y.).* Here 84 authorities tell us how they would treat 392 clinical entities. Individual preferences are stressed, but not to the exclusion of other recognized methods. It is strictly a book on treatment and as such is a worth-while reference work.

Medical Mycolgy, by G. C. Ainsworth, Ph. D., ($2.75. *Pitman Publishing Corp., New York 36, N. Y.),* is an introduction to its problems by a British Mycologist.

Answers to Your Questions About Pregnancy and Childbirth, by Carl Henry Davis, M. D., and Donita Ferguson, ($1.50. *Grosset & Dunlap, Inc., New York 10, N. Y.)* A handy manual done by an expert medical writer in cooperation with one of the leading obstetricians and gynecologists.

Insuring Special Class Risks, A compend for the Life Insurance Agent, by Donald E. Yochem, M. D., ($2.50. *The Insurance Research and Review Service, Inc., 123 West North Street, Indianapolis 9, Indiana).* This is a book which every physician who attempts to service the insurance

world by making physical examinations for life insurance should have on his desk. Special class ratings are often the best buy for the impaired risk. Too often, the applicant thus identified takes umbage and refuses to accept such a policy thereby depriving his dependents of the protection which they sorely need. Not infrequently we examiners do not discharge our full responsibility. We do not take time to explain to the applicant just what the Medical Director is going to be up against in making up his mind how best he can serve both the company and the applicant, given the facts as they are. If we did, we might well make our service worth more to all concerned.

The Psychology and Psychotherapy of Otto Rank, by Fay B. Karpf, ($3.50. *Philosophical Library, Inc., New York 16, N. Y.)*, an historical and comparative introduction to the theory and therapy of Otto Rank, his relation to Freud, Jung, and Adler, and to significant developments in the field of analysis, psychotherapy, counseling, education, and social work—one of the most significant figures in the modern psychoanalytic movement.

Doctors by Themselves—An Anthology compiled by Edward F. Griffith, ($4.50. *Cassell & Co., Ltd., London;* United States Distributor, *British Book Center, 122 East 55th St., New York 22, N. Y.)*. Five hundred pages of the most fascinating material—doctors of medicine writing of their work, their play, their troubles; how they look at life, death and immortality. Writings of medical men from the earliest times to the present. Every physician today will enjoy it all or part of it. A great gift to your interns or your colleagues.

Mechanisms of Urologic Disease, by David M. Davis, M. D., ($4.50. *W. B. Saunders Co., Philadelphia 5, Pa.)*, is designed by a distinguished teacher after a lifetime of experience to systematize the body of knowledge in the field of urology. So the author has turned from an arrangement based on anatomy to one based upon physiologic processes and their deviation from the normal, in the hope that he may supply rationalization to those of us who are in no position to supply our own.

Gifford's Textbook of Ophthalmology, by Francis Heed Adler, M. D., ($7.50. Fifth Edition. *W. B. Saunders Co., Philadelphia 5, Pa.)*. This revision of this successful text is based upon five years' experience in the use of the books in the classroom. The real purpose of a student textbook is to emphasize the important—not to recite all possible bits of knowledge. Here Gifford's text itself, and more particularly this revision have succeeded.

Two Essays on Analytical Psychology, C. G. Jung. Translated by R. F. C. Hull, ($3.75. *Pantheon Books, Inc., New York 21, N. Y.)*. Bollingen Series XX. The collected works of C. G. Jung, Volume VII. Contains the two famous essays, "The Relations between the Ego and the Unconscious" and "On the Psychology of the Unconscious."

Handbook of Medical Treatment, by Milton J. Chatton, M. D., Sheldon Margen, M. D., and Henry D. Brainerd, M. D., ($3.00. Third Edition. *Lange Medical Publications, P. O. Box 1215, Los Altos, Calif.)*, is the successful and most useful manual from the University of California.

Fool's Haven, by C. C. Cawley, ($2.75. *House of Edinboro, Publishers, Boston 11, Mass.)*. A story built around the legal anomaly that the parent who relies on faith and denies medical attention to his seriously sick child is convicted of a crime, yet the pastor who counselled the act goes free.

Familial Nonreaginic Food Allergy, by Arthur F. Coca, M. D., ($10.50. Revised third Edition. *C. C. Thomas, Publishers, Springfield, Ill.)*. This third edition of Dr. Coca's monograph presents important extension of his theory as well as further sketches on the concept of allergy. While the phenomenon of hyper-reaction to foods is an important observation and one which all physicians would do well to investigate, nevertheless, in your reviewer's opinion, it would serve Medicine better if the term allergy were to be reserved for hyper-immune reactions. Anyone, however, interested in headaches; hives; polio; the common cold; the effects of cigarette smoking; multiple sclerosis; glaucoma and what the author calls Idioblastic Symptoms Peculiar to Women (dysmenorrhea, nausea of pregnancy, relative sterility, frigidity, et al.), will want to include this in his reading.

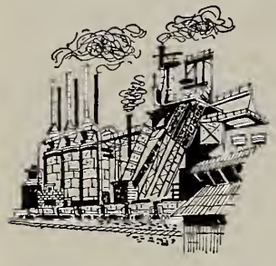
Vaginal Infections, Infestations, and Discharges, by J. B. Bernstine, M. D., and A. E. Rakoff, M.D., ($10.00. *The Blakiston Co., Inc., New York 22, N. Y.)*. This monograph is the only one in English known to the author on this subject, yet it is a common complaint among women. Emphasis is placed upon the disturbed physiology which predisposes to a vaginitis with its attendant discharge.

Handbook of Orthopaedic Surgery, by Alfred Rives Shands, Jr., M. D., in collaboration with Richard Beverly Raney, M. D., ($8.00. 4th Edition. *C. V. Mosby, St. Louis, Mo.)*, attempts to present the consensus of opinion as recorded in the orthopedic literature, criticized and tempered with the experience and thinking of 24 teachers of orthopedic surgery.

Bacteriology, by Arthur H. Bryan and Charles Bryan, ($1.85. Fifth Edition Revised. *Barnes & Noble, Inc., New York 3, N. Y.)*, covers the sanitary, medical, agricultural, and industrial aspects of the subject with a supplement on bacterial physiology, a glossary, and examinations.



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Vol. 50 January, 1954 No. 1

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Some Recent Advances in Etiology and Treatment of Kidney Stones*

ARTHUR J. BUTT, M. D., JOSEPH SEIFTER, M. D., and ERNST A. HAUSER, Ph. D., D. Sc.

DURING the past few years, there has been a change in thinking that is gradually replacing the static mineralogical concept of kidney stone formation by considering one of a more dynamic bio-pathological nature. Previously, there has been possibly too great emphasis placed on the pleomorphism of stone, and there has been a reluctance to recongize a more basic mechanism of deranged physiology.

PHYSICAL CHEMISTRY OF URINARY COLLOIDS

When one considers the physical chemical relationship existing in urine, it is surprising that formation of urinary calculi is not more common. The solubility of some of the stone-forming salts is relatively low, particularly at the *p*H that may exist in the urine. Urine is a highly saturated solution of extremely complex composition in which the concentration of electrolytes, as well as non-electrolytes, often exceeds the limit of solubility in pure water.

The unusual solubility of stone-forming salts in urine depends largely upon the presence of certain colloids which prevent the precipitation of salts and other colloids. If the concentration of such protective colloids is insufficient,[1 to 8] or not of proper molecular weight, the crystalline nuclei are sensitized and stone formation begins or is accelerated.

Ord, 1871, was the first investigator to use the term "colloid" in connection with crystallization, although not in its modern sense. Lichtwitz and Schade, in 1909, demonstrated that the abnormal solubility of stone-forming salts in the urine depends upon the presence of certain colloids which prevent precipitation, agglomeration and conglomeration of these salts and certain other colloids. Systematic colloid-chemical studies of the urine, which included chemical analyses, ultracentrifuge and surface tension determinations, ultraphotomicrographic examinations, and electrophoretic studies, offer definite proof that the urine of individuals with renal calculi is deficient in protective colloids.[3 to 8]

In the presence of hydrophilic colloids, the electrolytes are thought to bring about gelation, thus embedding the inorganic matter in the gel. Stone formation is prevented in a normal individual

*Address presented before the Toledo Academy of Medicine, March 13, 1953. This work was aided by a grant from Wyeth, Incorporated, Philadelphia, Pa., and on contract with the Office of Naval Research, Contract Nonr-926(00).

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by sufficient concentration of hydrophilic colloids in the urine. The hydrophilic colloids, if capillary-active, act as a peptizing agent and protective colloid, thereby preventing growth or agglomeration of crystalloids.[5]

EFFECT OF HYALURONIDASE ON URINARY COLLOIDS

While studying possible methods of increasing the protective urinary colloids which would aid in prevention of stone, the influence of serendipity on science generally and on medicine particularly came to our aid. A hospital orderly noted that whereas one patient's catheters and drainage bottles previously had to be changed at frequent intervals because of calcareous deposits, the drainage apparatus suddenly ceased to be encrusted with such desposits. By checking the hospital chart we found that a few hours before the urine became clear, the resident had added hyaluronidase to the hypodermoclysis fluid in order to facilitate absorption. Further investigation showed that subcutaneous injection of hyaluronidase, mixed with physiologic salt solution, resulted in clearing of urine in patients who previously had turbid urine with much sedimentation.

Additional physical chemical research demonstrated that when examined ultramicroscopically, urine sediment of people not susceptible to kidney stones is free from unprotected crystalline material, as the crystalline substance is covered with a jelly-like protective colloid. The sediment of the urine from patients with kidney stones shows an abundance of unprotected crystalline material which is due to a decrease or relative absence of protective colloids. Injection of hyaluronidase promptly alters a pathologic urine so that it appears normal. Under normal conditions, the proper colloid-crystalloid balance is maintained by a hyaluronidase substrate (hyaluronic acid) which is excreted in the urine.

Testicular hyaluronidase is an enzyme having the property of depolymerizing the muco-polysaccharide, hyaluronic acid, a characteristic and essential component of the intercellular ground substance. Ultraphotomicrographic studies demonstrated that potassium hyaluronate added to voided urine acted as a powerful dispersing or peptizing agent and that the injection of hyaluronidase results in the release of a protective colloid in the urine which dispersed crystalline material of all types by increasing their solubility. Addition of hyaluronidase directly to urine does not produce this clearing effect, therefore, we proposed that hyaluronidase acted indirectly by the release of hyaluronic acid at the site of injection with subsequent excretion in the urine.

HYALURONIDASE THERAPY

As a result of these observations, hyaluronidase therapy was instituted for the treatment of patients with severe renal calculous disease

TABLE I

Analysis of Laboratory Data of Fifteen Patients with Primary Stones (Group A)

ANALYSIS OF STONES—11 PATIENTS	9	Calcium oxalate or calcium oxalate and apatite
	1	Each cystine, uric acid
URINE CULTURE		Negative for growth 13 patients
	1	B. coli
	1	Staphylococcus aureus, non-urea splitting
PATIENTS GENERALLY REQUIRED	3	150 T. R. U. every 24-48 hours
SMALLER DOSAGE OF HYALURONIDASE	9	300 T. R. U. every 24 hours
THAN GROUP B	3	600 T. R. U. every 24 hours

TABLE II

Analysis of Laboratory Data of Twenty-one Patients with Secondary Stones (Group B)

ANALYSIS OF STONES—7 PATIENTS	5	Apatite and ammonium magnesium phosphate
	1	Apatite and calcium carbonate
	1	Cystine
URINE CULTURE	5	B. proteus
	5	Staphylococcus aureus, urea-splitting
	3	P. aeruginosa, 1 B. coli
	7	Mixed infection—non-urea splitting, 1 negative
PATIENTS GENERALLY REQUIRED	2	300 T. R. U. every 48 hours.
LARGER DOSAGE OF HYALURONIDASE	10	300 T. R. U. every 24 hours
THAN GROUP A	7	600 T. R. U. every 24 hours.
	2	600-900 T. R. U. twice daily

TABLE III

Summary of Results Following Administration of Hyaluronidase for Renal Lithiasis

GROUP	Stone formation controlled	Stone formation slowed	Stones smaller and less dense	Stone formation not controlled
A—15 cases	9 (60.00%)	3 (20.00%)	1 (6.67%)	2 (13.33%)
B—21 cases	7 (33.33%)	7 (33.33%)	1 (4.77%)	6 (28.57%)

in which no previous form of therapy had been effective. Observations to date indicate that patients vary widely in the quantity of hyaluronidase required to clarify pathologic cloudy urine. Such clarification is the most convenient clinical method of determining response to this form of treatment. Hyaluronidase therapy has been used in 36 patients suffering from rapidly forming or malignantly recurring renal calculi. These patients had passed numerous stones at regular intervals over a period of years or new stone formation developed within a period of weeks or a few months.

It was found that hyaluronidase was much more effective in controlling the formation and growth of primary stones, previously considered as idiopathic, then secondary stones, those developing as a result of stasis and infection, hyperexcretion of crystalloids or other known factors. It is now believed that the former type of stone is due to an innate or acquired deficiency of protective colloid. Table I illustrates laboratory findings and hyaluronidase requirements of patients with primary stones (Group A). Table II illustrates laboratory findings and hyaluronidase requirements of patients with secondary stones (Group B). Table III illustrates the results obtained in these patients.

ACTION OF BACTERIA ON URINARY COLLOIDS

Dosage requirements of hyaluronidase are much greater in patients harboring urinary infections, especially those due to Ps. aeruginosa, streptococci, or to urea-splitting organisms, particularly staphylococci or protei. It has been shown that some of these bacteria, particularly certain staphylococci and certain streptococci, produce hyaluronidase. Bacterial hyaluronidase differs from testicular hyaluronidase in that the former does not merely depolymerize hyaluronic acid, but carries the process down to end products of low molecular weight, which have no effect as protective colloids. The presence of bacterial hyaluronidase, particularly in an infected site over which urine passes, results in degradation of the hyaluronic acid present in the urine by the bacterial hyaluronidase and therefore removes protective colloids.

Many bacteria, notably those of the pseudomonas group, but also some streptococci, some staphylococci and some coli, produce hyaluronic acid which is present in the capsule. This hyaluronic acid is of a considerably higher molecular weight than the hyaluronic acid normally excreted in the urine. The high molecular weight hyaluronic acid, such as that produced by pseudomonas organisms, instead of exerting a protective colloid effect has a marked precipitating or anti-protecting action. These recent observations may help explain the specificity of certain bacteria in the production of renal calculi, such as has been shown for streptococci by Rosenow and for staphylococci by Hellstrom and Joly.

RELATIONSHIP OF SEX, RACE, AND PREGNANCY TO STONE FORMATION

Tensiometric studies on the urine after it has been subjected to ultracentrifuging, by which all matter visible in the microscope had been removed, have shown conclusively that increased protection due to urinary colloids results in a decrease of the surface tension of the urine.[5] Reduction in surface tension following injection of hyaluronidase closely correlates the clearing of turbidity and sediment if these are present initially.

We have observed from surface tension determinations on urine specimens from 600 subjects, that the incidence of primary stones is almost inversely proportional to the surface tension of the urine. In increasing order the incidence of primary stones is as follows: pregnant Negro females, pregnant white females, Negro females, Negro males, white females, white males. The average surface tension of the urine in these groups increases in this order.

It has been found almost universally that primary renal calculi are more common in men than in women. The incidence of secondary stones occurs with more equal distribution in the two sexes. Primary renal stones are practically nonexistent in the purebred South African Negro. In the United States, kidney stones do occur in the Negro although with definitely lower incidence than in the Caucasian. This is consistent with the fact that a large percentage of the Negro population in the United States is mulatto or has some admixture of white blood. In the mixed races of South Africa, the incidence of renal calculi approaches that found in the white race. These findings caused us to consider the possibility of a close correlation between the cause for differences in the white and Negro races, differences in the sexes, regardless of race, and marked changes during pregnancy.

The parturient woman with dilatation and stasis of the urinary tract, often complicated by infection, should be very prone to develop renal calculi. Yet, analysis of collected series of 49,000 obstetrical cases from various parts of the United States, revealed only 15, or 0.03 per cent, complicated by stone. This would indicate that pregnancy does not predispose to calculous formation, but actually aids materially in preventing the formation of stone. Urine from pregnant women, when subjected to ultraphotomicrographic studies, revealed pronounced increase in protective urinary colloids during the latter six months of pregnancy. This effect disappears about six weeks postpartum.

Some collagen diseases undergo remission during pregnancy, and this has been generally as-

sumed to be brought about by the increase in production of steroids. Seifter has stated that the remission may be produced by the marked increase in production and metabolism of hyaluronate occurring as a result of umbilical cord formation and the laying down of ground substance in the fetal tissues. He also feels that this reflects itself in the collagen system of the mother. The well known "bloom of pregnancy" appears in 8 to 12 weeks, when the placenta and umbilical cord are beginning to form. The infant's skin soon after delivery is soft, smooth and pliable. It is probably at these stages that the tissues contain the high content of hyaluronate.

We have observed in 24 of 40 patients who received large doses of hyaluronidase (300 to 5400 T. R. units daily) for a period of several months, that their skin became softer and smoother and the subcutaneous tissue more pliable.[6, 7] Generally, patients in the old age groups respond in this manner much more readily than younger people.

Hyaluronidase releases hyaluronic acid at the site of injection, in this case the skin and subcutaneous tissues. The hyaluronic acid begins to reconstitute itself shortly after the hyaluronidase action has been dissipated. During the period of repair, excess hyaluronic acid, or a hyaluronidase substrate is formed, part of which is deposited in the tissues, the remainder being present in the blood and then excreted in the urine.

Following prolonged administration of hyaluronidase, there is no change in the *p*H of the urine or in the urinary sodium, chloride, potassium, calcium or phosphorus excretion. Also the total urinary volume is not altered. There is increased excretion of total reducing substances and the most marked change is in the significant increase in excretion of glucuronic acid. The increased excretion of these substances, following administration of doses of hyaluronidase that can be safely injected into human beings, is not deleterious.

HYALURONIDASE, CORTISONE, STRESS, AND THE GROUND SUBSTANCE

It has been shown by Seifter, [9] Baeder and others, [10] that hyaluronidase is an excellent tool for attacking the ground substance and that its action is opposed by ACTH, cortisone and stress. We, therefore, attempted to ascertain whether adrenal steroids administered directly to the patient or released endogenously by stress would affect the urine and antagonize beneficial effects of hyaluronidase. If this were so, it raises the interesting possibility that urolithiasis may be another manifestation of dysfunction of the collagen system.

In six of eight patients receiving cortisone, we have observed that urine becomes more cloudy with increased sedimentation, which could not be accounted for by alteration of the hydrogen ion concentration. Ultramicroscopic studies of the urine from these patients showed a striking crystalluria indicating suppression of the protective urinary colloids. This may be noted after administration of relatively small doses, 25 to 50 mg. every 6 hours, and the effects are manifest within 6 to 12 hours.[10]

Poutasse found that calculi are a frequent complication of Cushing's syndrome. Greenblatt, in a personal communication, confirms this and he and Heckel further add that patients with Addison's disease rarely develop urinary calculi. These observations caused us to consider the possibility that cortisone or stress decreased the amount of colloids or altered the degree of polymerization of the hyaluronic acid. In either case, the amount of protective colloid is decreased.

Aviators were subjected to stress by simulated high altitudes in the compression chamber and centrifuged under accelerations of 3½ to 5 forces of gravity. Three of the six individuals thus stressed showed increased cloudiness and sedimentation of the urine during the experimental period. Chemical analyses of blood and urine revealed that there was no appreciable shift of the hydrogen ion concentration to account for the increased turbidity and sediment. Ultramicroscopic studies demonstrated that the decrease in solubility and dispersion was due to a relative decrease of protective colloids during and immediately following the periods of stress. The urine of these subjects also increased in coloration, which is the reverse of that seen following administration of optimum doses of hyaluronidase.

Rabbits normally excrete a large amount of sediment in the urine. Seifter and Baeder have shown that bilateral adrenalectomy decreases the amount of sediment as does hyaluronidase. The effects of bilateral adrenalectomy and hyaluronidase are additive. From these studies, it would appear that the ground substance and protective action of hyaluronic acid is partly at least under control of the adrenal gland.

SUMMARY

Parenteral injection of hyaluronidase depolymerizes hyaluronic acid or a hyaluronidase substrate, part of which is excreted in the urine where it acts as an excellent protective colloid. By this means, it materially aids in preventing the formation and development of renal stones.

The effect of stress or administration of cortisone appears to render the hyaluronic acid incapable of attack by hyaluronidase. Bilateral adrenalectomy in rabbits decreases the amount of urinary sediment.

Hyaluronidase produced by certain staphylococcci and streptococci destroy the protective colloid hyaluronate in the kidney. High molecular weight hyaluronate produced especially by cer-

tain Pseudomonas act as a powerful precipitant and gluing agent.

Calculous disease may result from an inhibition of the mucopolysaccharides of the ground substance and may, therefore, be another manifestation of dysfunction of the collagen system.

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The Use of Digitalis Preparations In Congestive Heart Failure

The optimal benefits from the use of digitalis preparations in the treatment of patients with congestive heart failure are not attained in many instances because of a failure to appreciate their place and proper use in such therapy and because of unfamiliarity with the special properties of the various preparations available.

Digitalis therapy is the treatment of choice in congestive heart failure since it has a direct and specific action on the failing heart and should be used initially and in preference to salt-depleting regimens.

Digitalis to be effective must be used in adequate amounts, both in initial digitalization and in maintenance therapy.

There are a great variety of digitalis preparations, all of which have special properties with which we should be familiar. We should be discriminating in our choice of preparations and, in any given situation, use that preparation which is most suitable under the circumstances.—Reno R. Porter, M. D., and R. P. Beckwith, M. D., Richmond: *Virginia Med. Monthly*, 80:610, Nov., 1953.

KEEPING UP WITH MEDICINE

• IN THE CASE of pyogenic infections, it should be obvious that the ability of the organism to penetrate the tissue of his host is a matter of great importance. Investigations into the relationship of the role of the adrenal cortex to the inhibition of hyaluronidase-like substances are beginning to throw light on this subject.

* * *

• WE ARE advised to doubt the validity of a diagnosis of chronic brucellosis based upon subjective symptoms; a positive intradermal test with any brucella antigen and the absence or low titer of brucella agglutinins.

* * *

• THE LIST of circumstances under which hepatitis is transferred from one human being to another grows more fascinating every year.

* * *

• MILD INFLUENZA symptoms and even severe unexplained sickness in a patient who has been working with turkeys may suggest Psittacosis. Canaries, chickens and ducks have also been incriminated.

* * *

• THE DISORDERS most commonly considered now as "collagen diseases" are: hypersensitive states which result in sensitization reactions to foreign protein, drug allergies, blood incompatability in transfusion, acute glomerulonephritis, periarteritis nodosa, rheumatic pneumonitis, rheumatoid arthritis, disseminated lupus erythematosus, dermatomyosis, and scleroderma.

* * *

• MOST of our young men will subscribe to the statement that the concept of DISease is the first principle of Medicine but they fail to see while it remains under the control of the reason, it also appears in different versions in the march of time and is a subject of history with which they should concern themselves.

* * *

• IT IS ESTIMATED that some 90 per cent of all persons suffer from headache at sometime or other.

* * *

• PROBABLY not more than 10 per cent of headaches have anything whatever to do with refractive errors the patient may or may not have. The mere presence of a refractive error does not mean that the headache is due to eyestrain in any patient.

* * *

• THE RELATION of the headache in time and the extent of the use of the eyes is important. It means more in a bookkeeper at income tax time than in a farmer boy.

* * *

• FIBROSITIS of the occipital muscles is a frequent cause of headache there and evidently due to spasm of the muscles.—J. F.

Results of Therapy with Radioactive Iodine In Hyperthyroidism*

RICHARD E. GOLDSMITH, M. D., and EUGENE L. SAENGER, M. D.

THIS is a report of the data gathered on all those patients seen and treated in the Radioisotope Laboratory of the Cincinnati General Hospital and followed by one person from four to 20 months. This selection was made to insure uniformity in diagnosis, in interpretation of physical findings and in follow-up. The patients to be discussed all had fairly typical thyrotoxicosis clinically and all had radioiodine tracer studies that were within the range suggesting an overactive thyroid in this laboratory.

METHOD OF STUDY

In evaluating the response to therapy, a patient was considered euthyroid when the usual clinical criteria of thyrotoxicosis had disappeared, when the patient was gaining weight and when the basal metabolic rate determination was lower than plus 10 per cent.** The I-131 tracer study was not used to follow a patient's course after radiation therapy, because there is no predictable correlation between the tracer study and the clinical status at such times.[1]

For the purposes of this publication we have used the following diagnostic terms: *diffuse goiter* —to indicate goiters that are palpably enlarged in both lobes and the isthmus without appreciable nodularity; *multinodular goiter*—to indicate goiters which are either symmetrically or asymmetrically enlarged with obvious nodularity consisting of two or more lumps. No patient is included who had a single nodule alone, or superimposed on a goiter; all such patients were operated on in deference to the high incidence of neoplasia found in such lumps.

We are reporting on 22 patients who meet the criteria. Several of these patients presented complicated problems: Four previously had surgical therapy for thyrotoxicosis; two had previous radioisotope therapy, and several had received stable I-127 and/or antithyroid drug treatment. The two patients who had previous radioisotope therapy have not been called treatment failures since they were lost to follow-up shortly after being treated, and then reappeared one or more years later. Both had received relatively small doses.

*From the Radioisotope Laboratory and the Departments of Internal Medicine and Radiology, University of Cincinnati. (This work was supported in part by grants from the Montgomery County Division of the American Cancer Society, the Cancer Control Council of the Cincinnati Public Health Federation and by anonymous donors to the Radioisotope Laboratory.)

**Two patients had basal metabolic rate values of plus 24 per cent and plus 20 per cent when euthyroid, presumably because of respiratory problems unrelated to thyroid function.

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RESULTS

Among the 22 patients one was treated when essentially euthyroid as a result of methylmercaptoimidazole (tapazole®) therapy, and she has remained euthyroid without further antithyroid medication. Nineteen patients became euthyroid and remained so, and two have become permanently myxedematous. One of these latter patients was purposely made myxedematous because of a complicating severe cardiovascular problem.

The 22 patients included five males and the patients' ages ranged from 22 to 72 years. Fourteen had diffuse goiters, seven had multinodular goiters and one had no goiter. The diffuse goiters ranged in estimated weight from 30 to 120 grams, the multinodular goiters ranged in weight from 40 to 100 grams. Those with diffuse goiters received a total dosage of 3.7 to 22 millicuries of I-131, averaging 11.4 millicuries. The patients with multinodular goitres received a total of 6.5 to 45 millicuries of I-131, averaging 16.0 millicuries.

The patients with diffuse goiter became euthyroid within two to 16 months after starting treatment, averaging five months; two patients each required two doses of the isotope and one patient required three doses. The patients with multinodular goiter became euthyroid within one to eleven months, averaging five and one-half

months; one patient required two and another three doses of I-131.

As a rule the goiters in these patients became considerably smaller; 17 goiters either shrank to 50 per cent or less of the original size or became impalpable, none increased in size, and no patient retained a goiter of more than an estimated 60 grams weight. Therefore no patient was encountered who might conceivably require thyroidectomy following isotope therapy for cosmetic or mechanical reasons. Several of these patients were treated while in the hospital, but 19 of these patients were or could easily have been treated as outpatients. Some of the patients continued at gainful occupations throughout the duration of therapy, and most were able to go back to work within four weeks of instituting isotope therapy.

DISCUSSION

We have not observed any untoward reaction in any of the patients herein reported. We particularly have looked for changes in the hemogram, for thyroiditis and other phenomena occurring locally in the neck. We have not seen radiation sickness or a general worsening of the patient in a manner suggesting a therapy-induced increase in the degree of thyrotoxicosis. No patient was observed to develop cardiac failure following the institution of radioisotope therapy, although four were in cardiac failure at the start of treatment and rapidly became compensated.

Some of the patients received I-127 or methylmercaptoimidazole for a short time as adjunctive therapy following radioisotope treatment. These were given occasionally for study purposes and occasionally to control the thyrotoxicosis rapidly in a dangerously ill patient, particularly when the cardiovascular system was compromised from the outset. Drs. Werner and Hamilton have already reported on this particular problem.[2] The one patient who inadvertently developed myxedema as a sequela of treatment was the first patient treated in this hospital with radioiodine, and the only patient included in this study who was treated prior to June, 1951; she received the smallest dose, 3.7 millicuries. No other sequelae, such as hypo-parathyroidism, clinically observed thyroid neoplasia, etc., were noted.

The problem of dosage is a complicated one and quite possibly already discussed far more than is warranted by our present knowledge. We treated patients hoping to achieve the desired result with one dose. The size of the thyroid was estimated clinically by palpation plus roentgen-ray examination of the neck. This figure was multiplied by 0.16; no correction was made for uptake. As an example, a patient whose goiter was estimated to weigh 100 grams was given 0.16MC/gram or 16 MC I-131. We guess that the standard error in the estimation of the thyroid gland weight is about 30 per cent in cases where there is no evidence of retrosternal goiter.

When our dosage figures are compared to those in literature, it is noted that we used larger doses to treat Graves' disease and smaller doses to treat nodular toxic goiter than have most investigators. We have no ready explanation for this. It is possible that our treatment of one patient may be used as partial explanation. Two and one-half months after I-131 treatment this patient was more thyrotoxic than when first seen, with a basal metabolic rate of plus 66 per cent, higher than the pre-treatment value; but the I-131 uptake at 24 hours was only 6 per cent. If a second dose of I-131 had been given it would have irradiated little save the toilet bowl. We had no choice but to wait a while longer; and within the next four weeks she became clinically euthyroid.

Perhaps the effective dose needed to produce a remission in the noduluar goiter patient would be less if we performed tracer studies prior to each dose of radioisotopes and then followed the excretion of all therapy doses.

SUMMARY—CONCLUSIONS

(1) Twenty-two of 22 hyperthyroid patients treated with radioiodine have shown excellent clinical responses and are now euthyroid.

(2) The response of the disease to therapy was as prompt as is the case with surgical treatment when surgical preparation and post-surgery convalescence are considered.

(3) The response of the hyperthyroidism in the patients with multinodular goiter was as satisfactory as the response in patients with diffuse goiter.

(4) There were no post-therapy complications or unwanted sequelae except for myxedema in one patient.

(5) There was no patient who showed true resistance to I-131 therapy although multiple doses were needed in five instances.

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Quinidine Intoxication

The goal of quinidine in auricular fibrillation, the achievement of regular rhythm, may itself be the premonition of a serious or fatal toxic reaction to follow. It is likely that the reactions following quinidine regulation of fibrillation in the past interpreted as cerebral emboli in reality often represented this quinidine intoxication syndrome occurring shortly after regulation. It is not possible to offer rigid proof that the perverse results in these cases were in fact due to quinidine.—Reuben Berman, M. D., et al., Minneapolis: *Minnesota Medicine*, 36:1052, October, 1953.

The Reproductive Life History of a Bicornuate Uterus

J. E. MORGAN, M. D., and CARMEN T. REYES, M. D.

UTERINE anomalies due to incomplete fusion or total failure of fusion of the müllerian ducts in fetal life have long been recognized and reported as anatomical curiosities. Their clinical implications and particularly their surgical correction have been neglected in this country until the past few years.

Several classifications of varying degrees of complexity have been proposed but all revert essentially to the degree of union or non-union of the ducts. Complete union produces a normal uterus, cervix, and vagina. Complete failure of fusion results in a double uterus, cervix, and vagina. Incomplete fusion may result in several varieties of bicornuate uterus, ranging from a simple septum dividing a unified fundus to a definite two-horned organ with or without duplication of the cervix and vagina.

CLINICAL MANIFESTATIONS

Strassmann,[1] who did a great deal of the early work on the subject, has stressed the fact that the clinical pathology encountered seems to be largely independent of the degree of duplicity. He states that the following clinical manifestations are found:

(1) Dysmenorrhea and polymenorrhea;

(2) Dyspareunia and sterility;

(3) Habitual abortion, dystocia, mal presentation, and postpartum hemorrhage;

(4) Hematometra, hematosalpinx, endometriosis, and subsequent pelvic inflammatory disease.

Through the course of the past 20 years, it has been our privilege to follow the entire reproductive life history of a patient with a bicornuate uterus. She has demonstrated at one time or another almost every clinical symptom attributed to this condition, and we therefore feel her case history worth reporting, as calling attention to the clinical manifestations brought on by a uterine deformity. The patient, in addition to the symptomatology usually mentioned, has also shown certain deformities or injuries in her unborn babies which may or may not be attributable to the condition.

CASE HISTORY

The patient was first seen as a primigravida in 1934. She was 21 years of age, and apparently in good health. The menarche was at 11 years of age and her periods had been regular, every 28 days, with a five day flow. This first pregnancy progressed normally until the eighth month when she suddenly developed profuse vaginal bleeding accompanied by uterine cramps.

Submitted May 6, 1953.

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The patient was moved into Evangelical Deaconess Hospital, Cleveland, Ohio, and observed for several hours. She was having regular labor pains but there was little if any cervical dilatation and the bleeding continued to be rather profuse. A diagnosis of premature separation of a low lying placenta was made. She was given supportive therapy and a viable infant, weighing 4 pounds 14 ounces was delivered by classical cesarean section. No exploration of the uterine cavity was done at this time and we did not realize that we were dealing with a uterine abnormality. The diagnosis of premature separation was confirmed.

The baby had a rather unusual deformity of the left arm. The elbow was hyperextended about 30° and ankylosed. There was considerable atrophy of the muscles of the forearm and the hand was badly deformed. The thumb was small and atrophic, the first and second fingers were completely webbed, and one digit was completely missing.

Following this, no further pregnancies ensued for five years. In 1939 the patient was admitted to Evangelical Deaconess Hospital because of a miscarriage at about two and one-half months. After symptomatic treatment for a few days, she went home but was readmitted a week later with a recurrence of vaginal hemorrhage. A dilatation and curettage was performed to remove retained placental tissue. During the process of this curettage, it was noted that there seemed to be a division of the uterine cavity. This was the first time that we realized we were dealing with a bicornuate uterus.

In October of 1942, we again saw the patient in early pregnancy. At this time, she was 30 years of age, a gravida III, para I. During the early months of pregnancy she threatened to miscarry, but with bed rest and symptomatic treatment, the bleeding stopped and pregnancy progressed normally. At eight months, the bag of waters ruptured and mild labor pains began. The patient was again admitted to Evangelical Deaconess Hospital.

Examination at this time showed her to be in early labor with the baby in a transverse presentation. The head was in the left horn of the uterus, and the buttocks in the right, with the back presenting over the os. A repeat low classical cesarean section was performed and a 5 pound 6 ounce viable baby girl delivered.

Examination and exploration of the uterus at this time confirmed our previous diagnosis of

bicornuate uterus. There was a dividing septum extending several inches into the fundus, and terminating in a rather hard fibrous band. The position of the baby was confirmed. The baby's head, lying in the left uterine horn, had evidently been pressing against the fibrous septum causing a slough to form about 2 inches long along the right side of its scalp, extending down to the calvarium. Following surgery, mother and baby did well and the slough in the baby's scalp healed rapidly.

Six months following this second cesarean operation, the patient again entered Evangelical Deaconess Hospital in May of 1943 with an incomplete abortion. A dilatation and curettage was performed. Another spontaneous abortion at approximately two and one-half months occurred in July, 1944. This again failed to complete spontaneously and a curettage was performed.

In April of 1946, the patient entered Fairview Park Hospital, Cleveland, with another spontaneous abortion. Vaginal bleeding ceased and she was discharged but had to be readmitted later and a curettage was performed for retained placental tissue.

During 1945 and 1946, the patient developed increasingly profuse and prolonged menstrual periods. This menorrhagia did not yield to any conservative therapy and in November she was admitted to Fairview Park Hospital. Hysterosalpingography confirmed the diagnosis of bicornuate uterus. A supravaginal hysterectomy was performed in order to control the patient's intractable menorrhagia. At this time, she was 34 years of age.

The gross pathological report revealed that the uterus was composed of a single fundus having a dividing septum which descended to within 1 centimeter of the internal os.

In resumé, in a period of thirteen years, the patient had six pregnancies, four of which ended in miscarriages. Two of the pregnancies were carried to approximately eight months. In one of these, she developed a premature separation of a low lying placenta necessitating cesarean section. In the other, the baby presented transversly after rupture of the membranes and a cesarean section was again performed. One of the babies showed a peculiar deformity of one arm and the other had a slough of its scalp caused by pressure against the dividing septum of the uterus. There was also one five year period of unexplained sterility. In her mid-thirties, the patient developed such intractable menorrhagia that it was necessary to perform a hysterectomy.

DISCUSSION

As previously mentioned, the clinical symptoms incident to uterine abnormalities may vary a great deal and are not necessarily dependent upon the degree of malformation. Undoubtedly many women with uterine abnormalities go through a normal reproductive life and their anomaly is never even suspected. Fenton and Singh,[2] in a survey of the deliveries at Sloane Hospital over a 25 year period, found the incidence of congenital anomalies of the reproductive tract to be one in 263 deliveries or 1.15 per cent. They reported the usual complications such as ante-partum hemorrhage, toxemia, abnormal presentation, and premature rupture of the membranes. Only 56.1 per cent of their pregnancies went to term. Their corrected spontaneous abortion rate was 16.5 per cent.

Having seen this case rather early in our professional life which manifested, at one time or another, almost all of the pathological attributes applicable to the condition, we have taken considerable interest in the subject for many years. It is obvious that one of the principal symptoms is the inability to carry a pregnancy to full term, the pregnancy terminating either as a miscarriage or premature delivery. We therefore decided some time ago that all women with a history of unexplained repeated abortion or premature labors should be studied to rule out uterine abnormalities.

HYSTEROSALPINGOGRAPHY URGED

This can be done in several ways. It is occasionally possible to suspect the condition from the clinical configuration of the pregnant uterus. Sometimes intrauterine examination, either with the instrument at the time of a curettage, or manual exploration at the time of a premature delivery, will show a dividing septum. If there is still any doubt, these women should have a hysterosalpingogram. If these investigations are done routinely, a surprising number of uterine abnormalities turn up in cases we have been classifying as idiopathic habitual aborters.

In our own private practice, we have found seven other patients with uterine abnormalities. Six had varying degrees of bicornuate uterus and one a complete reduplication. One patient had two miscarriages, then with complete bed rest for five months, carried a baby to term. The child presented in a peculiar oblique manner and a cesarian operation was performed. After two years, she attempted another pregnancy. This time she was not able to favor herself with as much bed rest and threatened to miscarry on several occasions. She did carry the baby to eight months, when she went into labor with the child in a transverse presentation and was again delivered by cesarean section.

Another patient was diagnosed after three unexplained miscarriages, and now having remained in bed during four and one-half months of her pregnancy, has reached the stage of fetal viability. Therefore, we feel that if the diagnosis is made, it is possible by careful attention to detail, including long periods of bed rest, to carry many of these women to near term. We do, however, face the prospect of frequent malpresentations and a high percentage of operative deliveries.

INJURY TO FETUS

Another point of interest in our case was that both children carried to viability had defects or injuries that might conceivably have been caused by the uterine anomaly. The first child had the badly deformed arm previously described. In

the past, such deformities were attributed to pressure from amniotic bands or strangulation from loops of cord during development. Recently the explanation of Streeter[3] has taken precedence. He feels that such deformities are due to an inherent growth defect in the local germ plasm.

However, when the uterine configuration is such that it repeatedly makes it impossible for a developing ovum to accommodate itself to the available cavity, resulting in an abortion, it would seem that the constricting and irregular confines could injure a child who remained in the unfavorable environment. This might be accomplished either by local pressure or by interference with the circulation.

The second child had a linear slough on its scalp extending through the skin and subcutaneous tissue and exposing the skull for about 2 inches. We feel that this was undoubtedly due to the pressure of the fibrous dividing septum. In reading on this subject of uterine deformities, we have not seen any mention of the occurrence of injury to the fetus. We call attention to this possibility so that others may watch for it and accumulate data.

As we stated earlier, both the clinical manifestations of uterine anomalies and any attempt at their surgical correction, have been largely neglected in this country. In Europe, more attention seems to have been given to their clinical symptomatology and attempts at their surgical correction have been carried out for many years. Ruge[4] appears to have been the first to attempt surgery. He divided the septum in a woman with a uterus septus, who had had two miscarriages. Within a year she delivered a full term infant per vaginum. This operation was repeated by others but of course was not sufficient in a really divided uterus.

Paul Strassmann[1] in 1907 was the first to unite the cavities of a divided uterus. His patient had had eight pregnancies, all of which terminated as premature deliveries or miscarriages. He delivered the uterus vaginally through the anterior wall and by splitting transversely and reuniting longitudinally, reconstructed one uterine cavity. She had a normal full term infant per vaginum within a year and a half and subsequently had five more full term infants. After Strassmann's work, the operation became well known in Europe but little attention was paid to it in this country.

Recently E. Strassmann,[5] a son of the originator, collected a total of 128 cases reported in the literature, including five performed by himself. The elder Strassmann performed 17 of the operations which bear his name. Of these 17, he did eight by the vaginal route. This, of course, was because of the greater safety of the vaginal approach in those early days. Most of the operations that have been done recently including those by his son, have been done by the abdominal route because of its greater technical ease. Of the 128 patients operated on, there was only one death. This was from a pyosalpinx ruptured at operation in the days before the advent of the modern adjuncts to surgery.

In these 128 cases, 83 known pregnancies occurred following surgery; 71 went to term, 61 delivered vaginally, 10 delivered by cesarean section there were 10 miscarriages, and in two the results were uncertain at the time of publication. There were no maternal deaths among the pregnancies following surgery and in no case was there rupture of the uterine scar during pregnancy. Strassmann feels that the uterine scar seems to be better in this type of surgery than that which forms after a cesarean operation. Seventy out of the 71 full term infants were born alive, one infant died in utero prior to a cesarean operation for placenta praevia.

It is also interesting to note that in these 128 cases operated on, a high percentage of menstrual disorders cleared up following surgery. In the same 128 cases, an analysis of 110 pregnancies which occurred before operation showed that only four went to term, 17 ended prematurely, 77 resulted in miscarriages, and in 12 the results were unknown. This shows a remarkable fetal salvage following surgical correction of a divided uterus. In the next few years, we in this country should improve our understanding of the symptoms produced by these anomalies, diagnose them more often, and develop the technique of their surgical correction.

CONCLUSIONS

A case is reported which gives the reproductive life history of a bicornuate uterus. This woman, in spite of a relative infertility, had four spontaneous abortions, two premature deliveries by cesarean section, one because of a premature separation of the placenta and early labor, the other because of a transverse lie and early labor. Then in her mid-thirties, she developed an intractable menorrhagia necessitating a hysterectomy.

Attention is called to the possibility that injury may occur to a fetus developing in a deformed uterus.

It is urged that hysterosalpingography be performed on all women with repeated abortions or early labors to rule out the possibility of a uterine deformity.

Surgical correction of such deformities is possible and should be attempted more often.

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Pneumococcic Brain Abscess: A Case Report—Treatment and Recovery

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ABSCESS of the brain occurs less frequently since the use of chemotherapy and the antibiotics.[1] Because of this an abscess may be overlooked as a causative factor in the production of either focal or generalized convulsions.

Occasionally an abscess of the brain will produce an acute surgical emergency. Prompt treatment of the abscess can be life saving.[2, 3, 7] The following case history is illustrative of this.

A CASE REPORT

The patient, an 18 month old white female child, was brought to the emergency room at St. Mary's Hospital, Cincinnati, on the evening of January 2, 1953, with generalized convulsions.

The history as obtained from the mother revealed that one month prior to admission the patient had had tonsillitis and infected ears. She had responded promptly to penicillin and symptomatic treatment. Nine days prior to admission she developed a mild case of chickenpox. Six days later she became irritable, began to pinch and bite, refused all solid food and cried more or less continuously. Her behavior continued to become worse. However, she showed no evidence of fever, vomiting or other signs of physical illness.

On the day of admission she suddenly "raised up, hollered, and fell back as though dead." Her color became ashen and she did not move. The lifesaving squad was called and she was taken to the hospital by ambulance. En route she was given oxygen and artificial respiration.

A review of the patient's past history as told by her mother revealed that she was born after a normal pregnancy in an uneventful manner. The child's growth and development were normal and she had had no serious illnesses. A review of the various bodily systems gave nothing pertinent to the present illness.

Physical examination in the emergency room revealed that the patient was an unconscious, well nourished, 18 month old white female. During the examination she began to have a convulsion. The head and neck became hyperextended, the eyes were roving and the arms were jerking in a clonic manner. The convulsive movements were more pronounced on the left side than on the right. The pupils were approximately 4 mm, regular, equal, and round. They did not, however, react to light. The pulse rate was 100 and the respiratory rate was 16.

The convulsion stopped spontaneously and the patient began to cry irritably. In addition, she began to thrash about and attempted to bite the examiner. Examination of the heart and lungs revealed no abnormalities. Examination of her nose and throat was likewise negative.

Neurologic examination revealed increased deep reflexes throughout and a strongly positive extensor response on plantar stimulation on the left. There was no paralysis or apparent paresis noted.

Before completion of the examination she had a convulsion, stopped breathing, and became comatose. The left pupil rapidly dilated and the eye movements stopped. Funduscopic examination showed severe papilledema bilaterally. It appeared to be somewhat more pronounced on the right than on the left. Examination of the ears showed that the drums were intact and there was no evidence of inflammation.

Emergency treatment, consisting of ½ cc. of epinephrine solution of 1:1000, was given intramuscularly. In addition, 20 cc. of 50 per cent glucose were given slowly intravenously. At the same time artificial respiration was begun. After approximately five minutes she began to breathe spontaneously.

A diagnosis of increased intracranial pressure due to abscess was considered likely.

TREATMENT

The patient was immediately taken to the operating room. The head was shaved preparatory to ventriculography. Bilateral burr openings were made in the occipital region. A brain needle was inserted on the right side. At a depth of 5 centimeters, thick creamy yellowish-green pus was encountered. This was under marked pressure and literally poured from the needle. Approximately 30 cc. of pus were aspirated. An immediate smear of the pus revealed gram negative diplococci. Following this the "abscess cavity" was irrigated with 10 cc. of aqueous penicillin solution (50,000 units). When the irrigation returned clear 5 cc. of penicillin solution were allowed to remain within the "cavity." At this time 2 cc. of pantopaque® were injected into the cavity for subsequent checking of its size and position by x-ray.[7]

No attempt was made to needle the left side of the brain.

The wounds were then closed in the usual manner and the patient was returned to the ward. She was immediately placed in an oxygen tent.

COURSE IN THE HOSPITAL

Immediately following the operation the patient was given 200,000 units of aqueous peni-

Submitted June 4, 1953.

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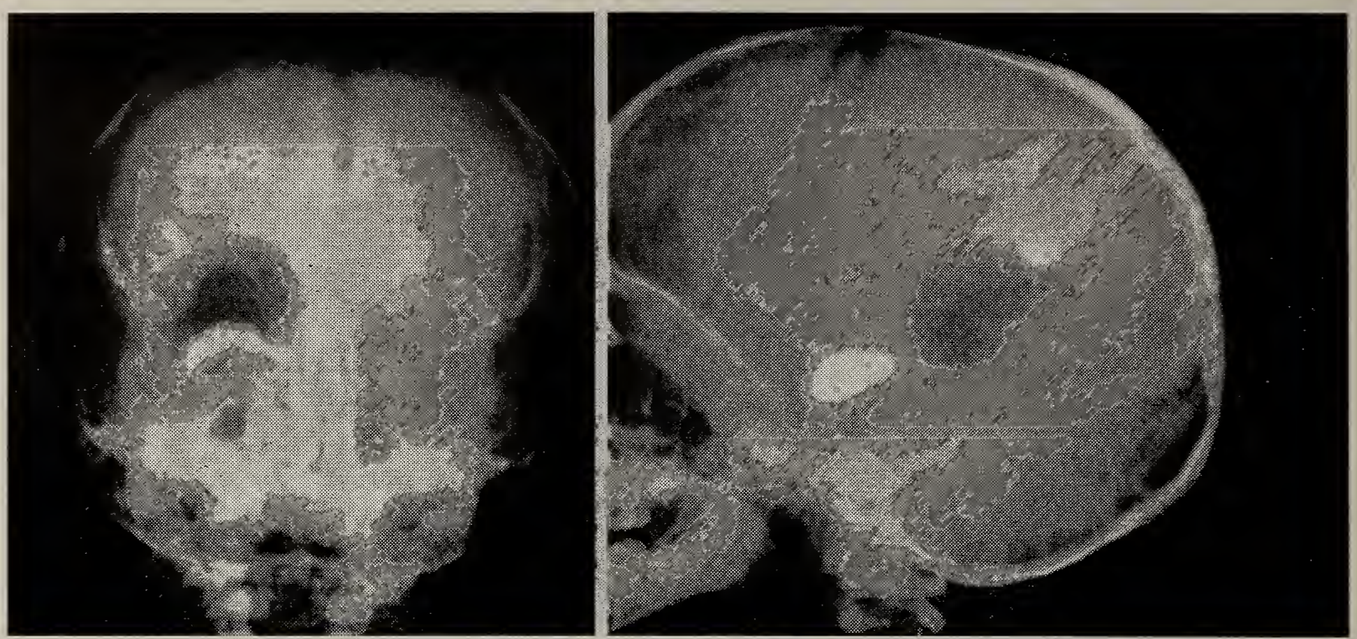


Fig. 1. January 3, 1953

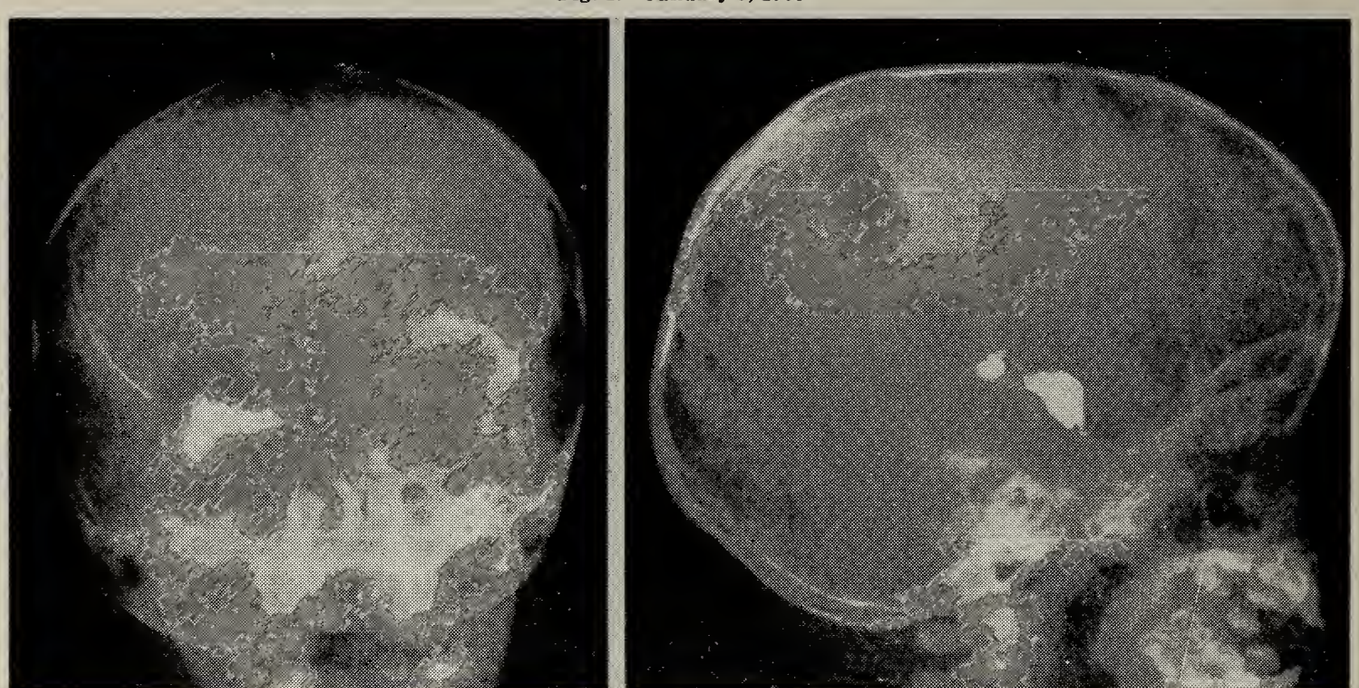


Fig. 2. January 8, 1953

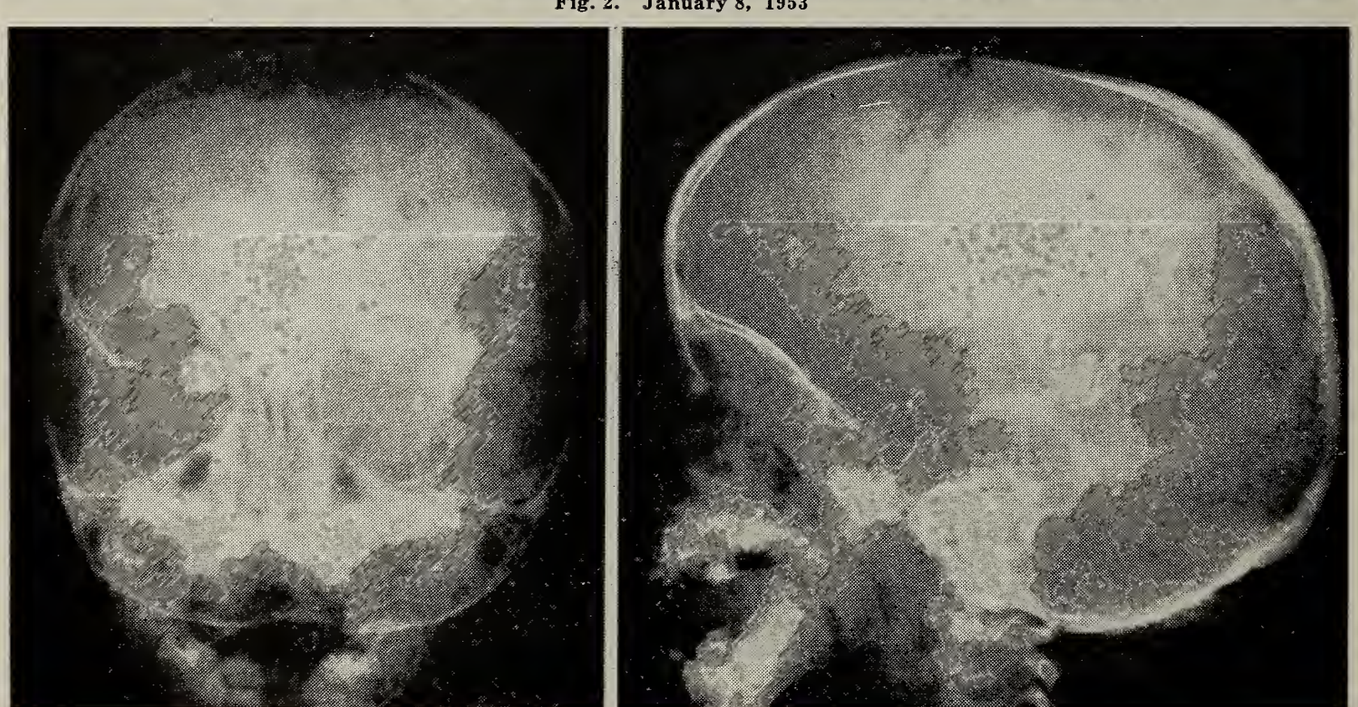


Fig. 3. January 15, 1953

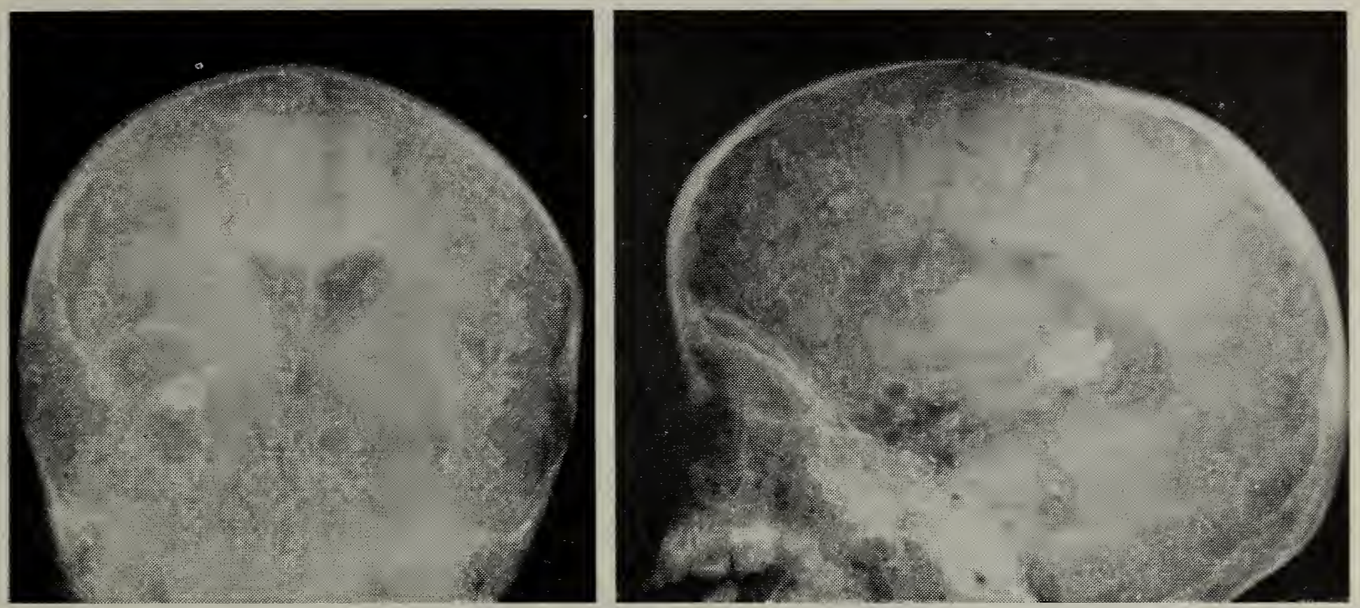


Fig. 4. January 21, 1953

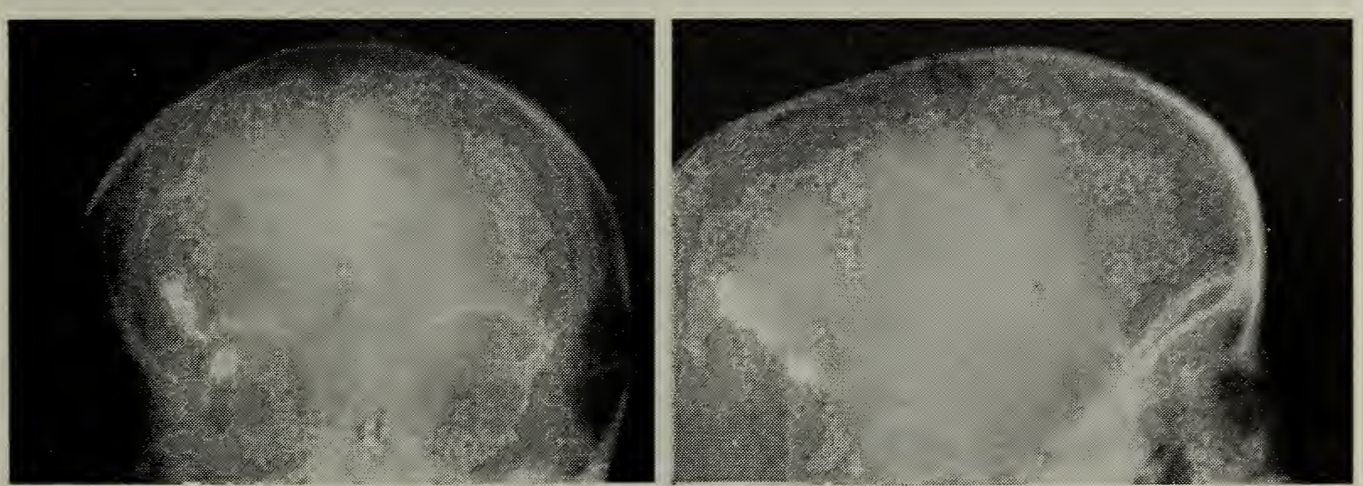


Fig. 5. May 21, 1953

cillin intramuscularly. In addition to this she received 1,000,000 units of Neo Penil® also intramuscularly, awaiting the culture and sensitivity tests.[4] The temperature following operation was 102.2°F. rectally. On the fourth postoperative day this returned to normal and remained so throughout the hospital stay.

The culture proved the organism to be a pneumococcus which was very sensitive to penicillin. For 14 days after operation she received 500,000 units of Neo Penil® twice daily. Following this for a period of two weeks she received Neo Penil,® 500,000 units, once daily.

Improvement was rapid and dramatic. The patient was alert the day after surgery and the irritability disappeared at the end of a week. Ophthalmoscopic examination at the end of one week revealed that the papilledema had disappeared. Repeat skull films at frequent intervals showed a progressive diminution in the size of the abscess cavity (figures 1, 2, 3).

Pneumoencephalography was done three weeks following surgery. This revealed normal ventricular filling with the presence of a small amount of pantopaque® which was not distorting the ventricular pattern (figure 4).

FOLLOW-UP

Examination four months after dismissal from the hospital revealed no complaints and no neurologic deficit. Roentgenograms showed a diminution of the size of the abscess cavity (figure 5).

SUMMARY

A case report is presented of a brain abscess which occurred in an 18 month old child, whose presenting symptoms were convulsions and coma, secondary to otitis media.[5, 6] It illustrates the importance of early diagnosis, prompt evacuation and adequate antibiotic therapy.[2, 4]

Acknowledgment: We wish to thank Dr. Nicholas M. Katona for suggesting that this case report be published.

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Psychiatric Orientation in a Juvenile Court Setting*

CHARLES L. LANGSAM, M. D., and OSCAR B. MARKEY, M. D.

THE historical background of the treatment of juvenile delinquents in this country is worth reviewing, but the purpose of our paper will be to outline the part psychiatry has been assigned in the development of Juvenile Court procedure and function.

According to Reinemann[1] the beginning was instituted by a law passed in Illinois in April, 1899, to go into effect on July 1st of that same year. This law created the first Juvenile Court "to provide care for neglected and dependent children and to use methods of treatment instead of punishment for delinquent children." Prior to this law there had been some help for delinquent children in other countries, most notably in Canada, South Australia and Switzerland.

THE FUNDAMENTAL IDEA

It might be well to record here the philosophy as proposed by the Committee of the Chicago Bar Association which is still applicable up to the present time. Their philosophy is stated as follows:

> "The fundamental idea of the Juvenile Court law is that the State must step in and exercise guardianship of a child found under such adverse situations or individual conditions as developed crime. . . . It poses a plan whereby he may be treated, not as a criminal, or legally charged with crime, but as a ward of the State, to receive practically the care, custody, and discipline that are accorded the neglected and dependent child, and which, as the act states 'shall approximate as nearly as may be that which should be given by its parents.'"

It was not until as late as 1938 that there was a Federal Juvenile Delinquency Act passed in this country. It is now estimated that at the present time there are a total of about 3,000 Juvenile Courts in this country.[2, 3] Detention facilities still remain almost completely inadequate in a great number of the communities. Some Juvenile Courts in this country, for a period, attempted to close their Detention Homes altogether. This did not turn out to be good. It was found that it is best to have a restricted center of an institutional type.

ESTABLISHMENT OF JUVENILE COURT IN CUYAHOGA COUNTY

It was just last year that the Cuyahoga County Juvenile Court celebrated its Golden Jubilee, having first seen the light of day in 1902. Its inception was sparked in 1901 by a talk delivered by Newton D. Baker entitled "Conditions of Children in Cleveland's Jails." After an inspection of the Chicago Juvenile Court, which had started some two to three years before, there was a bill introduced and passed in the Ohio State Legislature permitting the establishment of a Juvenile Court in Cuyahoga County.

From that point on, changes and progress occurred more or less consistently. There was the hiring of full time probation officers and caseworkers, and finally a Detention Home to take the place of volunteer homes which had proven very quickly to be completely inadequate.

The first psychiatric service in the Cuyahoga County Court was much later than the actual beginning of the Court. Before 1922, or for the first 20 years of its existence, there was practically no psychiatric work done with the Court children. What little was accomplished was performed by appointed practitioners willing to serve occasionally for a witness fee. In 1922 an Observation Clinic, under Dr. S. C. Lindsay, was set up by the Children's Bureau in the Children's Aid Society. This was taken over three years later by The Demonstration Child Guidance Clinic which was sponsored by the Commonwealth Fund. Dr. Lawson G. Lowrey and a trained staff were placed in charge. This project was then taken over by the Community Fund in 1927 and became the Child Guidance Clinic.

FULL TIME COURT PSYCHIATRIST

By 1929 the psychiatric studies of the children at Court by these various clinics had increased to the point that it appeared advisable for the Court to have its own psychiatrist. Judge Harry L. Eastman helped greatly in promoting the passage of a bill which was passed by the Legislature allowing the Court the authority to employ its own physician, psychologist and psychiatrist. On January 1, 1930, Dr. A. T. Childers was appointed and served for nine months, and

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Submitted April 27, 1953.

then he resigned to accept another position. He was succeeded by Dr. Donald H. Linard who served until his death in March, 1933.

Several months later Dr. Milton E. Kirkpatrick came to the Court and resigned in March, 1935. Dr. M. A. R. Hennessy was appointed as the Court Psychiatrist in May, 1935. While Dr. Hennessy was with the Court, in addition to his work with the children, he contributed to the program of community education in a series of radio talks on delinquency and mental health under the auspices of the Welfare Federation. Dr. Hennessy remained with the Court until his death in 1942, and then throughout the war it was not possible to obtain the service of a child psychiatrist with the requirements desired by the Court.

FULL TIME SERVICE CURTAILED

With the termination of Dr. Hennessy's tenure there has been no further attempt to employ a full time Court Psychiatrist. During the war years, the Court secured, through psychiatrists in private practice, such services as were urgently required from time to time. The service was re-established in March, 1946, on a part time basis by one of us (O. B. M.).[4] There was at one time a question as to whether a full time psychiatrist offered any advantage over part time services. A psychiatrist with broad experience in children's work might well prefer to maintain multiple functions rather than to limit himself to Court psychiatry.

For a short period the function of the Court Psychiatrist was devoted almost exclusively to the direct examination of children. In 1947 the recommendation was made that there should be a fairly large number of staff conferences with the caseworkers and supervisors, pointing to the necessity to more carefully examine the psychiatric elements in the case work and the case work dynamics. For a period of time one of us (O. B. M.) remained the only member of the psychiatric staff, devoting approximately two half-days a week to the work.

THE PRESENT SETUP

At the present time the total amount of psychiatric help available has risen considerably to a total of three full days. With the addition of the other members, Dr. Markey took on the function of coordinating all psychiatric services and was freed for considerable attention to in-service consultation and training, leaving more of the direct examination of the children to the other physicians. His function is nominally that of chief psychiatrist. In addition to the authors, who offer three sessions a week at the clinic, Dr. J. F. Berwald and Dr. W. R. Adams each carry one session in the Psychiatric Clinic. A psychiatrist is available on almost every Court day.

It has been only in the past two years that we have been able to accurately state that we now have a Psychiatric Clinic in the true sense of the word. One of us (O. B. M.) used the material from the Court in a panel discussion of Psychiatric Aspects of Sex Offenses at the American Psychiatric Meeting in 1949.[5]

Each psychiatrist with his different background and training can bring to the various discussions his own ideas and opinions to strengthen the healthy attitude and discussions in the Court setting. It is worth emphasizing that the four psychiatrists bring individual viewpoints to the work, one of them being largely experienced in adult psychiatry with increasing work with children, and the remaining three working more exclusively with children. Essentially a psychoanalytic discipline is followed, and three of the men are completing their training analyses.

STIMULATING DISCUSSIONS BY STAFF

I would like to mention just a few situations that arose as a result of the staff conferences, and which are still under discussion. One was the matter of the meaning and advisability of pelvic examinations of girls in the Detention Home. Some of the psychiatrists tend to believe that such examinations might be severely traumatic to the girls involved. Thus the opinions expressed suggested that psychological trauma might occur in uncommon instances.

The physician who did the examinations, and who is not a psychiatrist, stated that he was not aware of any negative effect on the girls. Of course this physician, who is a trained pediatrician and an expert in performing and evaluating pelvic examination findings, is oriented along "practical" rather than psychoanalytic lines. It was his opinion that the atmosphere of the clinic was relaxed, that the attending nurse was a warm, accepting person and that there was no authoritative attitude which might contraindicate the pelvic examination any more than the rest of the physical examination.

The question was raised as to the purpose of the examination. It was brought out in the discussion that the examination does not in any way prove that there has been sexual intercourse, and that the main objective appeared to be the discovery of the presence or absence of a venereal disease, or the presence of pregnancy. The fact that these matters could be determined by other means was discussed.

In relation to the proof of sexual relations, some of us wondered why it was any more necessary to prove this for the girl than for the boy, as it pertained to the total social planning. In any event it was pointed out that the dissemination of any of this information to parents or to others concerned with the child, should be done extremely guardedly.

On the opposite side there were questions as to whether we could dogmatically assume that such pelvic examinations were traumatic to the girls.

One can suggest that the pelvic examination can offer erotic pleasure, rather than pain, to the adolescent girl and that this offers a challenge for evaluation. No doubt many of these girls who were examined had had previous experience through masturbation, fondling and intercourse. Even if the examination is traumatizing, need we assume that it is permanently damaging? The countertransference factor may prompt one psychiatrist to fear, and another psychiatrist to perhaps minimize, this factor. Digital examinations can be done in properly selected cases. Inspection may suffice in routine examinations.

QUESTION UNSETTLED

The question has been discussed with the judge, with the casework supervisors and the chief probation officer, and it remains open at this time. This is an example of the fertile and stimulating discussions that have arisen since a broad program of intramural education has developed.

The other situation which arose was our concern in regard to the confidential nature of the material gathered by the probation officer and the psychiatrist, and our belief that there is a certain amount of security warranted as to the use of this material in the Courtroom procedure. It might be well to think in terms of having the content of the psychiatric examination made available to the judge but kept in the psychiatric files. It might well be that the psychiatrist's formulation and recommendations would suffice for presentation at the time of the child's hearing.

In this Court setting the social worker should be thought of as representing and protecting the child, so that the child may feel that the social worker is identified with him rather than with the Court authority. The social worker can very likely learn to protect the child from hearing certain destructive evidence which he may feel is a sign of violation of his confidences or which may reveal the child's parents in an unfavorable light which he may not have understood before.

It might be well to say a few words in regard to the clinical material that is seen in the Court setting. The majority of patients who are seen fall into the category of juveniles. We do have occasion to examine adults when these adults are in some way involved with a child in the Court setting. We see adults who have contributed to the delinquency of minors in situations such as rape. We also see parents in cases of neglect of children where there must be a determination as to the fitness of the parent to continue the custody of the child or children in question.

It must be understood that we see only a very small percentage of the total intake of the Court. It would be exceedingly cumbersome and also poor economics to attempt to see all of the children brought to the attention of the Court. We do not in any way attempt to see children in regard to the seriousness of the offense for which they are brought to the Court, but rather because of their own personal emotional integrations. We might mention that the reasons for referral to the Court include many categories such as automobile theft, stealing, injury to person, truancy, runaways, sex offense, destruction of property and situations where the children are considered to be beyond parental control.

CLASSIFICATION OF DIAGNOSES

As an example of the number of cases seen by the Psychiatric Clinic in comparison to the total number of delinquency complaints, we might pick out one particular year, when there were a total of 4,650 delinquency complaints. During that year there were 208 psychiatric examinations of children and 37 examinations of adults. The classification of diagnoses that we have used up to this point and the number of children seen in the year mentioned is as follows:

Diagnosis	Children	Adults
Conduct disorders	87	----
Immaturity	28	----
Psychoneurosis	26	----
Character disorder (psychopathic personality)	18	----
Mental conflict	15	----
Character defect	11	----
Schizophrenia	9	----
Latent schizophrenia	4	----
Preschizophrenia	2	----
Psychopathic	2	----
Organic inferiority	1	----
Character neurosis	----	17
Simple adult maladjustment	----	8
Active psychoses	----	3
Alcoholic deterioration	----	3
Psychoses	----	2
Encephalopathy	----	1
Paranoid state	----	1
No psychopathology	5	2
Total patients examined	**208**	**37**

REFERRALS FOR STUDY

We are of the opinion that the children referred for psychiatric study are best selected by the judges and the professional staff. An attempt is made to see those children for examination where the psychological situation is more serious, and where it is the impression that more than merely environmental manipulation will be necessary. Before the child is seen by the psychiatrist, a complete social history is obtained and whatever psychological testing is considered necessary. This history and testing is made available to the psychiatrist before his direct examination of the child.

After the interview with the child there is a conference with the caseworkers and the psychologist before the final decision is made as to disposition. At this conference we attempt to understand more thoroughly the dynamics involved. There is a discussion of the theoretic possibilities of treatment and/or placement, and a consideration of the reality factors involved. Many times it is necessary to compromise, with

a program that is not the most ideal one, because of these reality factors.

In the final writeup the psychiatrist carefully avoids too specific or too binding a set of recommendations. The function of the psychiatrist is merely to help the judge and not to specifically set limits on his possible decision.

We set up staff conferences at regular intervals with the professional staff in an attempt to promote a more active integration of the professional and the administrative services, to raise the professional standards of the group and to help the psychiatrist make recommendations within the limits of reality. We hope by this plan to stimulate interest in a more cooperative educational plan, possibly involving the various professional schools in the local university.

DISCUSSION GROUPS

Recently it was thought advantageous to have regularly scheduled discussions at which the judge and the psychiatrists could in an informal manner understand each other's thinking and ideas in regard to diagnoses and the disposition of the children. The reality limitations, and many other topics which affect the relationship between the psychiatrist and the judge are discussed. We hope to continue these discussion groups in the future. We would like to emphasize that no program can be any more effective than is acceptable to the judge of the Court.

Seminars with the probation officers (caseworkers) were started this past Fall, and an attempt was made to keep it as informal a discussion group as possible. There was a tentative outline to be used for the 12 weekly sessions that was to comprise the course. It is as follows:

OUTLINE FOR SEMINARS

I. Consideration of the criteria for referrals for psychiatric study.

Under this heading it was felt that: (A) There should be a discussion as to the referral when the worker and/or the supervisor was seeking further explanation for baffling behavior suggesting deeper hidden causes;

(B) When the worker feels that he is in need of help in clarifying his own role in therapy. This would include problems of countertransference and techniques of dealing with agency workers outside of the Court. It would also involve problems dealing with other informants, including parents and teachers;

(C) When the worker sees a need for placement and would like to have help in clarifying the functions and methods of a treatment agency;

(D) Where the psychiatrist needs to be used as a liaison between the Court and the psychiatrist or other physicians in private or hospital practice. In all of these problems the individual or total child should be referred. No specific "problems" need be thought of as strictly in the realm of psychiatry.

II. Preparation of a psychiatric history.

Under this heading would be included the techniques in obtaining material. This is to be looked upon as being much more important than the facts themselves. Added to this should be a consideration of the effect on the child of the interview experience.

III. Preparing the child (or parents) for psychiatric examination.

Here the caseworker must learn to define the nature of psychiatry and the meaning of the psychiatric interview in order to encourage the child to understand and discuss matters as freely as possible. The caseworker should explain the psychiatrist's views only with caution, and it is important to avoid having the child think of the psychiatrist as the final authority, because only the judge is final in this respect. The child or the parent again should be made to understand that the psychiatrist is chiefly the one who **helps** the probation officer and the judge to better understand the dynamics of the situation.

IV. The significance of case material.

In the developmental history one should be aware that very important clues can be obtained as to the emotional readiness of the parents or the child in question, and also the significance of a slow tempo in the child's development as against a true defect.

V. The nature of the psychiatric examination.

Here the social worker is the responsible professional and should have in readiness specific questions for the psychiatrist, and should prepare as full a history as time and conditions will permit. The caseworker should be encouraged to be ready at all times to stimulate the psychiatrist to explain the dynamics in as much detail as the caseworker would like to have.

Other topics, such as the meaning of the staff conference and the nature and use of confidential material, which have been previously referred to, have also been covered in these sessions.

In the seminars at first the burden of the discussion was carried by the supervisors, but in a relatively short period of time the caseworkers began feeling more comfortable in offering comments. One worker was able to say that he thought that some of the psychiatric examinations were unnecessary or inappropriate; and that many times these examinations being done by the psychiatrists kept the psychiatrists from seeing more abnormal situations which were more pressing.

In another discussion as to the content of the history, the important fact was brought up that the judge needs to know certain factual details as well as interpretation of situations. This discussion was in regard to the social history. It was pointed out that with familiarity and ex-

perience, the worker will in time not have to follow the outline literally, as is necessary in the beginning. An outline, however, was considered as necessary in order not to allow the interview to follow only the emotional readiness of the worker and the client at the time of the interview.

During discussion in another session there appeared to be a need for the workers to have a better understanding of the normal neuropsychologic landmarks and progress from birth through infancy. Again the emotional attitude was stressed in pointing out that as an example a complete obstetrical history is relatively unimportant as compared with an idea as to the general emotional behavior and attitude of the parents toward the pregnancy. It was also pointed out that it was more important to learn of a parent's attitude toward a baby's crankiness than to spend a great deal of time gaining evidence of possible organic birth trauma which might make the baby irritable.

In another discussion numerous examples were given of normal and distorted habit patterns in the first five years of life, along with their meanings. In the informal discussions case material was used from the clinic whenever it was felt necessary. Many times this made the situation more alive to the workers in the discussion.

THE CASEWORKER'S IMPORTANCE

One very important topic which was discussed (covered in general in the outline given previously) was the importance of the caseworker during the child's Detention Home experience. It was felt by one of the workers that the child, during this period, feels exceedingly dependent on the caseworker and wants to be kept informed as well as wanting attention from their workers. It has been the experience of the Detention Home workers that these children have a very definite kind of possessive pride when they are visited frequently by their caseworker. It was suggested that caseworkers make rounds frequently so that the children in the Detention Home would come to feel that they were being seen casually and warmly without any specific step or message being involved. These are part of the factors involved in the idea that the worker is a therapist, even though he may not think of himself as such.

DETENTION HOME PERSONNEL

In regard to the Detention Home experience as lived through by the child, we have projected for the future a closer correlation between the Detention Home and the Juvenile Court workers. This will probably involve a training course for the Detention Home workers and an attitude of acceptance by them, that, among other things, they can work with the caseworkers rather than apart from them, or against them, as often occurs. It is certainly an advantage to the child to know that his worker will visit him during his period of detention. This also can be of advantage to the caseworker and the Detention Home personnel.

We are continually trying to make as an exhaustive and informative study of the various correctional institutions as possible, so that we may have better knowledge of the situations into which we must refer children for further care and help. We have compiled a book of the various institutions, and have had this revised from time to time as various workers visit these institutions, and can thereby give us a firsthand account of their own impression of the help afforded, the emotional tone of the institution and the response of the children to help that is offered.

SUMMARY

In summary, we have in our Psychiatric Clinic setup a series of essential aims which we are beginning to accomplish, and which we are of the opinion will continue to be accomplished in the future. In the past the psychiatrist has been considered essentially a diagnostician in the Court clinical team, but it is almost axiomatic to assume that he must consider that the Court experience for the child is a therapeutic procedure, in some sense as a prelude to whatever treatment is hoped for the child after he leaves the Court setting.

The fact that this is a therapeutic situation is one which the remainder of the professional staff must be made aware of at all times. In this regard we like to consider that the probation officer is basically a caseworker with the child and not just a probation officer in the exact meaning of the word. The caseworker can in many ways help the child to understand and benefit from his experience in the Detention Home prior to the hearing in the Court, and also help the child on the day of the Court hearing. If at all possible, the child's experience with the Court in its entirety should be made a continuous one rather than an interrupted contact with a number of different people.

We attempt to encourage a smooth informality of relationship between the caseworker and the Detention Home supervisor, so that the child can relate to the probation officer as a social worker who will function as his representative in this difficult experience. With this type of procedure, the caseworker can sustain his contact with the child from the beginning of his Court experience to the end.

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The Coxsackie Viruses in Clinical Practice

JOHN LEWIS THINNES, JR., M. D.

IN 1948 in Coxsackie, New York, two patients paralyzed with anterior poliomyelitis were being studied by Dalldorf and Sickles,[1] who were then attempting to adapt the poliomyelitis virus to a more suitable laboratory animal than the monkey. From the stools of these patients was isolated a filterable agent found to be pathogenic for suckling mice. Investigation of this agent showed that skeletal muscle paralysis and necrosis was caused within 2 to 10 days in the mice; and that the patients' sera, as well as pooled human serum or gamma globulin contained antibodies capable of neutralizing this agent. Subsequent virologic testing led these workers to conclude that they were dealing with an agent other than the already identified poliomyelitis virus, and it was later named the Coxsackie virus.

CLASSIFICATION OF THE COXSACKIE VIRUSES

Further research made it evident that many viruses could be classed with the original one, and there emerged a classification of these agents into groups A and B on the basis of the type of lesion produced in suckling mice. Although suckling mice and suckling hamsters have been accepted as the standard animals used for isolation of these new viruses, there have appeared later reports about adapting some of the group A viruses to the chimpanzee, chick embryo and tissue cultures; and some of the group B viruses to adult mice and the chimpanzee.

The group A viruses characteristically produced in the suckling mouse extensive lesions of skeletal muscle only, consisting of hyaline degeneration followed by necrosis and calcification; while the group B viruses caused skeletal muscle necrosis plus central nervous system lesions and visceral inflammations. These two groups at present include at least 15 immunologically distinct types, and still others will undoubtedly be identified.

The existing classification of these types is cumbersome and complex, with each type individualized by a number, letter and number, or named in honor of the person or place associated with its isolation while the various types within one group have been related to only one clinical syndrome. Since this is primarily a clinical paper, it seems advantageous to avoid confusion and discuss this large number of viruses primarily in relation to their group classification of A and B.

Testing by both complement fixation and neutralizing antibodies has been employed to serologically identify and type these viruses, showing that the complement fixation tests are often heterotypic and of little value, while neutralizing antibodies are specific. The latter test, however, is awkard and suitable only for research purposes at present.

A presentation before the Mitchell Pediatric Society of the University of Cincinnati College of Medicine, April 8, 1953.
This paper took First Prize in the Student Council Essay Contest at the University of Cincinnati College of Medicine, June 3, 1953.

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PREVALENCE—CHARACTERISTICS—DISTRIBUTION OF THE VIRUSES

In an effort to determine the prevalence of infection with the Coxsackie viruses a number of serologic surveys were conducted, one of which revealed that 40 to 80 per cent of those persons examined possessed neutralizing antibodies for any one of five types of the group A viruses. A similar survey of 150 people for one type of the group B viruses revealed an incidence of 77 per cent. Thus it is obvious that these are extremely common viruses.

When studied with the electron microscope the Coxsackie viruses were found to range in size from 36 to 38 millimicrons, which is comparable to the virus of poliomyelitis. They have been isolated from human feces, throat washings, sewage, and flies trapped near human habitation; and there are also reports (which are not considered valid now) of isolation from human blood, serum, brain, and spinal cord.

Coxsackie viruses have shown complete resistance to ether, penicillin, streptomycin, chloromycetin,® and aureomycin but are inactivated by heating to 51 to 60° C. for 30 minutes. Reinfection with a specific type virus has never been demonstrated, but simultaneous infection with two different types has been carried out. These viruses appear to have a world-wide distribution, and have been isolated wherever a valid attempt has been made. From the present data there does not seem to be any sex or race differences as to incidence; and they have been isolated from every age group, predominantly in childhood. In like manner though they have been isolated throughout the year, most are found in the late summer. As regards epidemiology, spread seems to be by direct contact with all susceptibles becoming infected, but only 30 to 50 per cent exhibit clinical symptoms.

DISEASES RELATED TO THE COXSACKIE VIRUSES

At present there are only two diseases which have been related to Coxsackie viruses; namely,

herpangina and epidemic pleurodynia. Before discussing these conditions, it might be well to say a few words about the confusion which exists in the early literature concerning the relationship of Coxsackie viruses to poliomyelitis.

In view of the fact that these viruses had been first isolated from poliomyelitis patients and were not uncommonly found in association with poliomyelitis, there was a great deal of speculation that they might play some etiologic role in anterior poliomyelitis, or in some way affect the severity of the paralysis in this disease. It seems clear from more recent work that the occurrence of Coxsackie viruses in poliomyelitis patients can be explained on the basis of chance, and that they do not alter the course of the disease. The following tables adapted from the work of

TABLE I

Relative Incidence of Coxsackie Viruses in Poliomyelitis and in Persons Without Poliomyelitis.

	Number	Number with Coxsackie Viruses	Per Cent Positive
Poliomyelitis	701	72	10.3
Not Poliomyelitis	1,062	98	9.2

TABLE II

Incidence of Coxsackie Viruses in 531 Poliomyelitis Patients.

	Number	Number with Coxsackie Viruses	Per Cent Positive
Paralytic	288	30	10.4
Nonparalytic	139	14	10.1
Unspecified	104	28	26.9

Huebner[6] and the group with the United States Public Health Service, who have done most of the conclusive work with these viruses, bear this out.

In addition there was an examination of 416 stools from poliomyelitis patients in 1950 and 1951 and Coxscackie viruses were isolated only five times from three patients subsequent to negative admission specimens, suggesting that the viruses had been acquired after hospitalization, not before. It is clear today that anterior poliomyelitis is not to be connected with herpangina or epidemic pleurodynia.

HERPANGINA

In 1920 Zahorsky[15] first described a specific febrile disease of childhood; in 1924 he published an excellent clinical description suggesting the name herpangina for the syndrome. Until recently this work was lost sight of, and several papers described outbreaks of this summer illness without recognizing it. So accurate and complete was Zahorsky's original description that recent authors have been able to add little more.

The onset of this disease is abrupt, with fever often becoming quite high sometimes accompanied by a convulsion. Malaise and anorexia are common and vomiting may occur. In many patients, headache is a prominent feature and this may be accompanied by abdominal and other pain. A mild sore throat is often present which can be severe enough to lead to dysphagia. The fever usually subsides within 48 hours and the patient is typically asymptomatic a few days after onset. No abnormalities have been reported in the peripheral blood, urine, or roentgen studies; except for oral abnormalities described below, the physical examination is usually normal.

As one can readily see, the above symptoms are diagnostically nonspecific and leave us with the need of some means of identifying the disease. This can be done by carefully examining the mouth and throat, where the presence of either characteristic small visicles surrounded by red areolae, or small punched-out ulcers on the anterior pillars of the fauces is considered pathognomonic of herpangina. Although these lesions can secondarily involve the throat, oral mucous membrane and tongue, they are primarily situated on the anterior pillars and often nowhere else.

In one instance a child was examined throughout the course of the disease and on the evening of the onset of symptoms only a diffuse redness of the throat was observed. The next morning dark red petechiae were found on the anterior pillars of both fauces, and by afternoon these had become papular and surmounted by a small vesicle. When observed the next day, these had become small punched-out ulcers surrounded by an erythematous area. At this point the patient was asymptomatic although the ulcers persisted for two days.

THE EPIDEMIOLOGY OF HERPANGINA

Following the isolation of the Coxsackie viruses in 1948 there appeared in the literature many reports of outbreaks of herpangina with a high incidence of isolation of the group A viruses with type-specific neutralizing antibodies in the patients' sera. Although one could say that these patients were infected with the group A virus and had herpangina, it was realized that these viruses were quite widespread and prevalent so that without an epidemiological study involving comparable segments of the population either in good health or with other disease, one could not establish group A Coxsackie virus as the etiologic agent of herpangina.

Such a survey was carried out in Parkwood, Maryland, by the United States Public Health Service under the direction of Huebner.[5] A description of this work is included not only to illustrate the relationship of the Coxsackie viruses to herpangina, but also as an excellent example

of controlled, scientific, investigative work along epidemiologic lines.

Parkwood, Maryland, is a suburban community of approximately 100 households and 300 or more persons. After August 1949 when a group A type II Coxsackie virus was isolated from eight cases of a summer grippe-type illness the community was put under epidemiologic surveillance. This consisted of taking careful case histories and the collecting of stool specimens from the inhabitants by a Public Health nurse for virus study. Prompt reporting by parents of any febrile illness was encouraged. From October 1949 until July 1950, none of the sporadic illnesses were associated with the presence of Coxsackie viruses in the stools.

In June 1950 when a routine survey was performed, stools from 283 persons contained no Coxsackie virus. Then on July 16, 1950, the 5-year old daughter of a physician developed the previously described signs and symptoms of herpangina. By July 18, she was clinically well but within the next 15 days five more cases occurred in children living in three nearly adjacent households.

Histories of the subsequent cases revealed that each had had close contact with at least one other patient, either during, or shortly after, the illness. Throat cultures on four of the cases were negative for pathogens. Stool specimens had been taken from each of these six children during the June 1950 survey and had been negative whereas specimens obtained during the early stages of each illness were positive for type H-3 group A Coxsackie virus, as were subsequent specimens 4 to 21 days later. The quantity of virus was usually greater in stools obtained during the acute phase than in those of the convalescent period. Throat swabs were taken in three patients within three days after onset and were positive for the virus while one taken five days after onset was not.

Two attempts at isolation of the virus from two of the patients from whole blood were unsuccessful. Serum obtained from four of the patients either prior to or within 24 hours after onset were negative for neutralizing antibodies against H-3 virus while high levels were found in their convalescent sera. Since neutralizing antibodies to other viruses tested were not found, this rising titer is considered specific.

SUBCLINICAL INFECTION

Of 283 stool specimens obtained during a routine survey in August, 1950, the H-3 virus was isolated from eight children and four adults in addition to the six children who had had herpangina. Three of these 12 persons lived in a household with a patient and the remaining nine were in close neighborhood contact with patients. Only one of these persons had a history of an illness suggestive of herpangina. Another routine survey in October 1950 showed only one of the six patients to be harboring the virus. The H-3 type was the only virus isolated from Parkwood during 1950. The method used to isolate the virus was standardized, and controls were used to insure accuracy and to eliminate false positives.

Additional cases of herpangina were studied in the Washington area during the summer of 1950 bringing the total to 37. Group A Coxsackie viruses were isolated from 32 of these patients and from many of their contacts. The following tables represent additional data gleaned from the Washington surveys:

TABLE III

Attempts to Isolate Coxsackie Viruses in Suckling Mice from Thirty-One Patients with Herpangina.

Source	Number	Number with Coxsackie Viruses	Per Cent Positive
Stool	30	25	83.3
Anal Swabs	21	12	57.1
Throat Swabs	29	17	58.6
Whole Blood	8	0	0

TABLE IV

Occurrence of Coxsackie Viruses in Various Groups: Survey Results from June 1 to September 29, 1950, in Metropolitan Washington, D. C.

	Number	Number with Coxsackie Viruses	Per Cent Positive
Survey Groups Including Well Persons, Poliomyelitis, Diarrhea, and Miscellaneous Diseases	992	10	1.0
Herpangina:			
Neighborhood Contacts	15	9	60.0
Family Contacts	35	14	40.0
Cases	37	32	86.5
Total	1,079	65	6.0

This survey established the group A Coxsackie viruses as the etiologic agents of herpangina; and, coupled with the previously discussed serologic surveys, indicated that herpangina is one of the most common minor febrile illnesses of children.

PLEURODYNIA

Group B of the Coxsackie viruses also was found to produce a clinical entity, namely epidemic pleurodynia. This disease was first described by Daae and Homann in Norway in 1872 and seems to be occurring with increasing frequency in both endemic and epidemic form. Although it is of widespread distribution the greatest number of cases has been reported from the lowlands of Europe. Three hundred and fifty-eight cases were reported in North Amsterdam alone in the summer of 1951 with a group B Coxsackie virus isolated at the University of

Amsterdam.[13] One of the earlier epidemics occured on the Island of Bornholm and the disease is frequently referred to as Bornholm disease. Other terms which have been applied to the condition are epidemic myalgia and devil's grippe.

Many mild cases of this disease occur and are characterized by a sudden onset, with fever, chest and abdominal pain, headache, and fatigability. The most prominent feature is usually the chest and abdominal pain which is related to respiration and often severe enough to lead to a pronounced sensation of difficulty in breathing. These symptoms may last from 1 to 20 days and recurrences are fairly frequent causing a prolonged convalescence. Even with severe symptoms the disease is apparently benign and self-limited, no deaths having been reported. As can be readily appreciated, these symptoms are paralleled by many serious conditions such as biliary colic, pleurisy, appendicitis, myocardial infarction, etc., so that in an isolated case the diagnosis is difficult.

The present data relating the group B viruses to epidemic pleurodynia are not as complete as with herpangina. There have been a few outbreaks reported in the literature in which a group B virus was isolated and some serologic studies were performed. One of these consisted of a laboratory infection at Yale,[14] with group B viruses, and resulted in symptoms of epidemic pleurodynia with complement fixation titer tests rising in all.

Probably the most completely studied outbreak occurred in Telephone, Texas, in the summer of 1951 and this too was studied by the United States Public Health Service under Huebner.[8] Twenty-two patients with the clinical diagnosis of epidemic pleurodynia, ranging in age from 3 to 84, were studied and Coxsackie viruses isolated from 18. Of these 18, sixteen had group B viruses, two had group A, and two a combination of both. Group A was found to be prevalent in the community so its occurrence in these patients was explained on this widespread incidence, and was not thought to be clinically significant. The antibody response was not as conclusive as in the Parkwood survey, with only seven of the 14 patients tested developing neutralizing antibodies to the group B viruses tested. Although there has not been a complete epidemiologic investigation utilizing controls (which is definitely indicated), it is felt on the basis of present information that at least several of the group B Coxsackie viruses are etiologically related to epidemic pleurodynia.

SUMMARY

At present we can say that the Coxsackie viruses are extremely widespread and that practically no one escapes infection with them even though only 30 to 70 per cent of persons so involved exhibit clinical symptoms. These viruses can be divided into two major groups, namely group A and group B on the basis of the type of lesion produced in suckling mice. This classification also has clinical significance in that the group A viruses are proved to be etiologically related to herpangina, an acute specific, self-limited, febrile illness of childhood identified by the presence of vesicles or small punched-out ulcers on the anterior pillars of the fauces. From the present data on the group B viruses, which are not so complete as data on the A group, it can be stated that in all probability they cause epidemic pleurodynia which does not exhibit a pathognomonic lesion but is characterized by fever and thoraco-abdominal pain related to respiration.

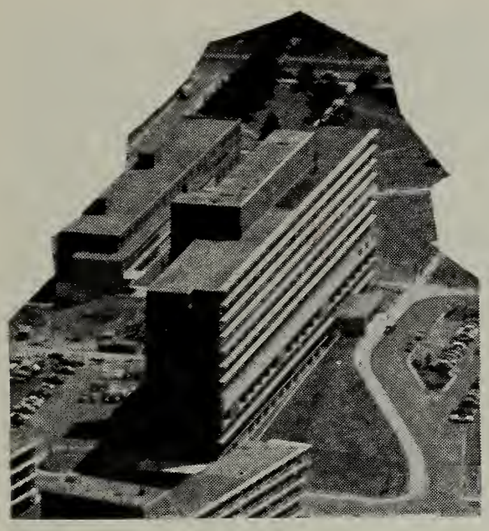
Recent work has established the etiology of these two diseases, herpangina and pleurodynia. More important it represents a stepping stone in medical progress, helping to clarify our concepts of the prevalence and relationship of viruses to human disease, and pointing the way for further investigative work.

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Neurotoxic Symptoms Follow Use of Antifungal Agent

Wilson et al., Hitch, and Featherston reported several patients with tinea capitis who developed neurotoxic symptoms following the use of the antifungal agent, asterol® dihydrochloride.—A. H. Ungerman, M. D., and M. S. Ungerman, M. D., Tulsa: *J. Oklahoma State M. A.*, 46:305, Nov., 1953.



A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Edward Goodsitt, M. D., President

Presented by John A. Prior, M.D., and E. von Haam, M.D. Edited by Dr. von Haam

PRESENTATION OF CASE

THIS 24 year old white female was admitted to University Hospital with the chief complaint of shortness of breath. The patient had had bronchopneumonia before the age of two and following that "kidney trouble" all her life. This was manifested by nocturia of five to six times and frequency during the daytime. She had had no edema, pyuria, hematuria, dysuria or other known urinary difficulties prior to six months ago. There was no history of joint swelling or pain, rheumatic or scarlet fever.

Six months prior to admission the patient developed an upper respiratory infection manifested by sniffles, cough, sore throat, laryngitis and slight fever. This subsided after several days. Following this episode she had gradually progressive edema of the lower extremities. One month before admission the patient developed dyspnea on moderate exertion but no orthopnea.

SYMPTOMS ON ADMISSION

Four days before admission she developed nasal congestion, sore throat, hoarseness and cough productive of red and dark blood. On the following day she had difficulty speaking but her throat was less sore. She became orthopneic and dyspneic at rest. Her ankles and legs became more swollen, and she became noticeably drowsy and passed less urine. These symptoms progresed and a physician who saw her 24 hours prior to admission told her that her "kidneys were bad and that she had pneumonia" and advised her to come to the hospital.

The past history revealed that the patient had never menstruated or had intercourse although married for five years. She had been divorced a year before admission.

Physical Examination: The patient was a pale, sallow, short white female who appeared acutely and chronically ill. The temperature was 100.8°, the pulse 124, the respirations 40, the blood pressure 160/90. She was very dyspneic with audible rales and rhonchi. The skin was warm. There was marked edema of all extremities and of the abdominal wall, posterior thoracic wall and the face. The retinal arterioles were tortuous and showed arteriovenous nicking; no hemorrhages, exudates or papilledema were present. The thyroid was not palpable. Both lungs contained loud moist rales and rhonchi throughout. There was no evidence of pleural effusion.

The heart was apparently not enlarged; the rhythm was regular and no murmurs were heard. The abdomen was soft and there was slight generalized tenderness; no organs or masses were felt. The vagina was narrow and about 1 inch deep. On rectal examination no uterus or adnexal organs were felt, but a vertical cord 6 to 8 mm. in diameter was palpable in the left lower quadrant. There was calf tenderness bilaterally.

Laboratory Data: The red blood count was 1.66 million, hemoglobin 4 Gm., white blood count 17,700 with 80 per cent neutrophils, 16 per cent lymphocytes. The urine had a specific gravity of 1.008, contained 350 mg. of albumin and a few white and red blood cells. The blood urea nitrogen on admission was 180.5 mg., the following day it was 191.5 mg., the third day 243 mg. The carbon dioxide combining power was 20 vol. per cent. On the day following admission the serum sodium was 145 meq., the serum potassium 7.7 meq., the serum phosphorus 12.81 mg., the total protein 4.73 Gm. with 3.35 Gm. of albumin. The Wassermann and VDRL tests were negative. Serum calcium on admission was 9 mg. Blood cholesterol was 162 mg.

X-ray Studies: A radiograph of the chest showed a greatly enlarged cardiac silhouette and generalized pulmonary edema. A pneumonic

infiltration could not be ruled out. An electrocardiogram showed no changes of acute myocardial damage or of electrolyte imbalance.

Hospital Course: The pulmonary edema persisted. The urinary output remained at or below 200 cc. daily. On admission the patient was given 1500 cc. of dextrose in water intravenously. Later that day when the carbon dioxide combining power was reported she received 160 cc. of molar sodium lactate in 500 cc. of water through Levin tube. She was digitalized and given a transfusion of one pint of whole blood. She was treated with penicillin and streptomycin from the time of admission. She was given sodium lactate intravenously daily and received a total of 3 pints of whole blood. The CO_2 combining power rose to a maximum of 34 vol. per cent and the red blood count to a maximum of 2.2 million. The pulmonary edema became more severe and a bloody frothy secretion oozed constantly from the nose and mouth. The patient expired on the fourth hospital day.

CLINICAL DISCUSSION

Dr. J. A. Prior: I understand that the clinical history was obtained from her stepmother, who had been with the patient since the age of eight, with only yes and no answers from the patient. This indicates the severity of the disease from the very onset of her admission. She was comatose at the time of her admission and within a few hours after her admission the resident had already noted on the chart that he anticipated at any moment the death of the patient. I state this to impress you with the severity of her illness and also to apologize for the scarcity of information about this girl's early childhood.

If we consider the past history of this young woman it would seem that the early stages of her illness date back to her childhood with the principal symptoms of nocturia of four to five times per night and diurnal frequency of urination. Nocturia can be divided into two different groups. Our patient had relatively frequent nocturia. By that we mean five to six times per night and sometimes more often, which suggests that it might be urination on an irritative basis with voiding of relatively small amounts of urine at frequent intervals. In contrast to this are the individuals with chronic renal disease and inability to concentrate who void one to two times during the night relatively large amounts of urine of low specific gravity. It would seem that this young woman fits into the former category. Then as the years went by she was in relatively good health but seemed to slowly develop renal insufficiency as a result of a smoldering disease involving her kidneys.

AZOTEMIA

Azotemia as you know may be prerenal or it may be renal. Prerenal azotemia follows a number of conditions such as upper gastrointestinal hemorrhages, vomiting and diarrhea with loss of fluids and electrolytes and severe dehydration. This form of azotemia is rather readily recognized because of the primary illness which is present and because of the normal specific gravity and concentration of the urine. Renal azotemia on the other hand always shows demonstrable impairment of the renal function with low specific gravity of the urine, together with other abnormal urinary findings.

Renal azotemia may develop very slowly in deed and shows a variety of symptoms. Cerebral manifestations are relatively common and may consist of irritability, depression, drowsiness, muscle twitchings and occasional convulsions with ultimate coma such as was present in this patient. Further manifestations of renal insufficiency are pulmonary edema with tachypnea or Cheyne-Stokes type of respiration. Pericarditis may develop with characteristic friction rub over the heart. This was never audible in this patient.

HYPERTENSION

Hypertension and more or less pronounced retinopathy are also common. These are often accompanied by manifestations from the gastrointestinal tract with anorexia, nausea and vomiting. There tend to be bouts of diarrhea and in the feces and vomitus blood is often present as a result of uremic gastritis and colitis. The skin is edematous and may show petechiae or large ecchymotic hemorrhages. From the symptoms of the patient we feel that she was suffering from a long-standing renal disease with steadily progressive renal failure over the past six months.

The next question is of course as to the type of renal involvement. Let me say that we are probably dealing with a chronically diseased kidney which is now in a stage of functional insufficiency. A further differentiation at this late stage is often very, very difficult. It is even difficult for the pathologist who has the specimen in hand and can study the tissue under his microscope, although I dare say Dr. von Haam has the answer in this case.

Certainly the diagnosis of chronic diffuse glomerulonephritis would have to be entertained as a possibility as far as this young woman is concerned. Her renal ailment supposedly started after bronchopneumonia whose etiology we do not know although it might have been caused by streptococci. We have no classic history of an early acute glomerulonephritis with hematuria, nor do we have the intermediate stage of nephrosis with edema and hypoproteinemia. Her blood pressure was only moderately elevated and the typical retinopathy of chronic glomerulonephritis was absent. Most important of all, however, the urine never showed pronounced

hematuria or the many types of casts we expect to find in chronic glomerulonephritis.

Arteriolar nephrosclerosis is another chronic renal disease which over years may lead to renal insufficiency and uremia. However, there are usually other signs of vascular sclerosis with pronounced and persistent hypertension and characteristic retinopathy which were not present in our patient. I think also that on the basis of age alone we can probably rule out the diagnosis of arteriolar nephrosclerosis. Malignant nephrosclerosis, which may be a terminal stage of any long-standing renal disease, usually also occurs later in life and runs a relatively short period of time, a year to three years perhaps. As nearly as I can determine the disease of our patient had its onset as far back as twenty years ago.

Chronic pyelonephritis seems to me to be the best diagnosis as far as this young woman is concerned. If we consider the entity of a chronic pyelonephritis we realize that its most important features are its insidious onset and its protracted and often symptomless course. Chronic pyelonephritis tends to be more frequent in women than in men and is perhaps one of the most common causes of mild hypertension in young women under 35 years of age.

THE ANOMALIES

With the very definite anomalies of her sex organs it seems to me very probable that this patient may also have had some anomalies in her urinary tract, such as an aberrant vessel, fibrous bands or a horseshoe kidney which may result in some degree of urinary obstruction. Urinary obstruction in the female is not as easily recognized as it is in the male, in whom we all are aware of urethral strictures and prostatic hypertrophy as common causes of obstruction. The patient's low-grade hypertension and her relatively insignificant urinary findings in the face of obvious renal insufficiency with uremia make it very probable that she had a smoldering low-grade pyelonephritis for many years. I am sorry that no retrograde pyelography was ever performed on this patient since this might well have revealed some urinary obstruction which could have been relieved.

POLYCYSTITIS

Polycystic renal disease is the final possibility which has to be considered. Polycystic renal disease has a congenital origin and during adolescence the kidneys tend to enlarge as to become palpable in the majority of cases. The azotemia is slow in onset and patients live for a long time with a very high blood urea nitrogen which often exceeds 300 mg. Our patient's kidneys were never palpable and her azotemia progressed very rapidly. I would therefore state on the basis of what I have learned from the chart that this young woman had, first, definite congenital anomalies of her pelvic organs and, second, that she had a chronic pyelonephritis in a terminal stage. Polycystic renal disease or chronic glomerulonephritis I would consider as much more remote possibilities.

CLINICAL DIAGNOSIS

1. Congenital anomalies of the pelvic organs.
2. Chronic pyelonephritis.

GENERAL CLINICAL DISCUSSION

DR. E. VON HAAM: You have heard the discussion of Dr. Prior. Any comments or questions?

DR. J. L. MORTON: This posterior-anterior radiograph of her chest shows a butterfly pattern of pulmonary edema which is more pronounced on the right than on the left. I see evidence of diffuse dilatation of the heart. She also has fairly normal breast shadows which may be of interest with regard to the abnormalities of her sex organs.

DR. PRIOR: As nearly as anyone was able to determine from the history of the report here, her sexual development had been essentially normal except for the fact that she had never menstruated as the result of the abnormality of her vagina. Her secondary sexual characteristics were all present.

PATHOLOGIC DIAGNOSIS

1. Chronic pyelonephritis, bilateral, severe.
2. Bilateral hydronephrosis and hydro-ureter.
3. Uremia.
4. Uremic pericarditis.
5. Pulmonary edema, bilateral, with hemorrhagic bronchopneumonia.
6. Gastrointestinal hemorrhage (uremic).
7. Accessory spleen.
8. Uremic colitis.
9. Rudimentary double uterus.
10. Atresia of vagina.
11. Parathyroid hyperplasia.
12. Uremic encephalopathy.

PATHOLOGIC DISCUSSION

DR. VON HAAM: The body was that of a well developed and fairly well nourished young female who appeared to be much younger than her given age. Her body length was just under 5 feet and the estimated body weight 110 pounds. The breasts were small and firm. The hair distribution and the external genitalia were those of a normal female. Her vagina consisted of a small pouch which was 2 cm. deep. The skin was pale and slightly edematous.

The patient's heart was quite large and weighed 340 Gm. Both ventricles appeared di-

lated and the left ventricle was hypertrophied. Both lungs were heavy and showed nodular dark-red areas surrounded by very edematous lung tissue. The mucosa of the stomach showed numerous small erosions and the colon contained irregular ulcers covered with hemorrhagic crusts. The bowel contained tarry feces.

The kidneys were very much decreased in size. The right kidney weighed only 45 Gm., the left 55 Gm. The kidney parenchyma measured 2 to 3 mm. in thickness. The kidney pelves of both organs were of normal caliber. Both ureters were uniformly dilated and measured between 8 and 10 mm. in diameter. The urinary bladder and female urethra appeared normal.

THE UTERUS

The uterus was absent and there was a cord-like structure on either side of the pelvis measuring 4 to 5 cm. in length and 8 mm. in diameter which apparently represented rudimentary horns of the uterus. The medial portions of both bands were confluent and assumed a triangular shape. Sectioning showed no uterine cavity but solid smooth muscle tissue. The lateral extensions of these cord-like strands were thin and round and contained fimbriae at the terminal ends. The ovaries were both present and showed pale smooth surfaces with numerous small cysts.

The microscopic examination showed focal pericarditis which we considered uremic in origin and a hemorrhagic pneumonia which had developed in edematous lung tissue. The hemorrhagic character of the pneumonia also made us think of a uremic lesion. The microscopic sections of the kidney parenchyma showed extensive colloidization of the remaining tubules with many hyalinized and a few infarcted glomeruli. The renal vessels appeared normal. The parathyroid gland showed marked hyperplasia of the functional cells. The pituitary appeared quite cellular with numerous eosinophilic and basophilic cells present. Section through the ovary showed numerous follicular cysts and graafian follicles. Sections through the uterus showed smooth muscle and fibrous tissue without any endometrium present.

THE ANSWER

In conclusion we may state that we have before us a young woman who showed a severe chronic pyelonephritis with evidence of long-standing urinary obstruction. This obstruction was undoubtedly produced by the congenital malformation of the internal sex organs which transformed the uterus into a tight muscular band which exerted pressure on both ureters and thus caused a high urinary obstruction.

Additional findings were those of marked hyperplasia of the parathyroid and pronounced infantilism with normal sexual development. The patient was less than 5 feet tall and one may even use the word dwarfism. Renal dwarfism or infantilism is a condition which is typical of chronic renal disease in children and most frequently observed in polycystic kidneys or juvenile pyelonephritis. The patient's blood calcium was low (only 9 mg.), her serum phosphorus was high (14 mg.). This suggests renal rickets which is probably the basis for her stunted growth and which also was responsible for the hyperplasia of the parathyroid gland. Renal rickets is most common in the more chronic kidney diseases such as chronic pyelonephritis.

Thus we see that not only the kidney lesion itself but the entire constitutional makeup of the patient seemed to point to the diagnosis which Dr. Prior has chosen and with which I fully agree. The lesions which we found in the lung the heart, the gastrointestinal tract and the central nervous system of the patient can be explained by a very slowly progressive state of uremia which started imperceptibly years ago and which finally caused the terminal illness of this patient.

GENERAL DISCUSSION

DR. MORTON: Radiological examination of both clavicles showed a certain frayed out fuzziness which is very typical of renal rickets.

DR. VON HAAM: I am glad that additional radiological confirmation has come forward.

DR. PRIOR: Could you call a girl who is feet tall a dwarf? If so there must be lots of dwarfs around.

DR. VON HAAM: I would probably call it rather renal infantilism than renal dwarfism.

DR. PRIOR: I wonder if the patient at some time had a kidney stone which was a factor in her renal obstruction. Most people who have been studying hyperparathyroidism found that it is most common in patients with renal stones

DR. VON HAAM: In your discussion, Dr. Prior you pointed out that you did not think it was case of chronic glomerulonephritis. Will you please re-emphasize this point?

DR. PRIOR: There are several reasons why we excluded chronic glomerulonephritis and preferred chronic pyelonephritis. First of all, there were no casts present in the urine. Second, there was at no time an outstanding hematuria. Third there was never a clear-cut history that the patient ever had a typical case of acute glomerulonephritis. Fourth, with the genital malformations present we thought strongly of the possibility of some obstructive lesion which in addition to an infection could produce a chronic pyelonephritis.

MEDICAL STUDENT: Did she have much edema

DR. PRIOR: When she came in she was quite edematous. She also had some decrease in pro

tein, anemia and typical capillary changes of uremia.

DR. HAMWI: Do you think this pneumonia had been present for a long time?

DR. VON HAAM: I think it was one of those recurrent uremic phenomena and not a true primary pneumonia.

MEDICAL STUDENT: I do not quite understand the etiology of the pyelonephritis in this case.

DR. VON HAAM: I presume two factors were involved in the pathogenesis of this lesion. First of all, there was a definite impairment of the renal flow through the pressure of this strong musculo-fibrous band upon both ureters. In addition she must have had an infectious disease when she was two years old which produced a renal infection which she could never completely get rid of. Thus a chronic pyogenic process established itself in the kidney which slowly led to renal failure. Do you agree with me in this explanation, Dr. Prior?

DR. PRIOR: I certainly do.

DR. VON HAAM: I do believe that it is very important from the therapeutic point of view to recognize and differentiate pyelonephritis from glomerulonephritis and the other renal diseases. This case might have been saved if it had been recognized properly years ago. This is quite in contrast to polycystic kidney and chronic glomerulonephritis in which even an early recognition usually cannot save the patient.

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Bacteria Insusceptibility to Antibiotics Reported Significantly Increased

Finland and Haight have reported a study of 500 strains of Staphylococcus aureus with respect to sensitivity to penicillin. They insist on the development of high-grade resistance occurring within the preceding two years and also a somewhat corresponding resistance to aureomycin and oxytetracycline (terramycin®).

They believe that bacteria, once having become resistant, are likely to remain so for an indefinite period even in those patients who have not received antibiotics. Cross-resistance to the various antibiotics occurs.

Jackson, Vicher, and Soska, in their study of hundreds of strains of staphylococci, state that the relative insusceptibility to antibiotics has significantly increased within the short period of approximately two years.—A. L. Tatum, M. D., Madison: *Wisconsin Med. J.*, 52:553, Oct., 1953.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Risorius—This muscle of the cheek which inserts into the angle of the mouth is literally named the "laughing muscle." Its name is derived from the Latin word "risus" or laughter and this muscle was so named by Santorini, an early 18th Century Italian anatomist.

Mosquito—A word derived from Spanish via Latin. It is a diminutive of "mosca or musca," a fly. The term was first used in English in 1583 by Phillips who in Hakluyt's *Voyages* says "A kind of flie—the Spaniards call them musketos."

Aedes—A genus of mosquitos having a cosmopolitan distribution. Certain species, such as the Aedes Aegypti are important vectors of diseases such as yellow fever. Because they are noxious and troublesome biters they were aptly named "aedes" which is a Greek word meaning disagreeable. This term is composed of the Greek "a," or not, and "edos," or pleasure.

Anopheles—This is the name of a genus of mosquitos and literally means "useless." The term is derived from the Greek words "an," or without, and "ophelos," or use. This mosquito was classified by Mergen in 1818 and was identified as the vector of malaria in 1890 by Sir Ronald Ross.

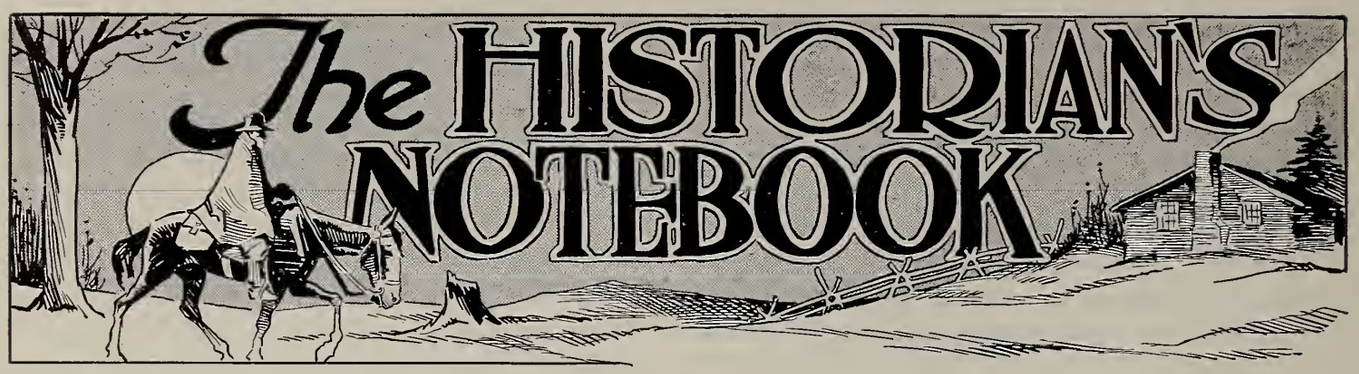
Estrus—Designating sexual desire, heat or rut in the lower animals, this term was formerly spelled "oestrus." It is derived from the Greek word "oistros" meaning a gadfly. In other words the goad of sexual desire was likened to a gadfly's provoking sting.

Estrogens—These are female sex hormones which are so called because they produce or generate heat or estrus. The term was coined from the word "estrus" plus "gen" which was shortened from generate. This name was first given to these sex hormones in 1926 by Parker and Bellerby who extracted them by means of fat solvents from the ovary and placenta.

Midwife—This term results from the ancient and natural helpfulness of woman to woman in her hour of need. The term "midwife" literally means "with the wife," and the word "mid" in this case comes from the German word "mit" meaning with. The terms midwifery and midwife were in common use up until the end of the 19th Century, but have now been replaced with the Latin obstetrics and obstetrician.

Blueblood—This term referring to the nobility had its origin in Spain and comes from the fact that the veins showing through the skin of pure-blooded Spanish aristocrats were bluer in color than those whose parentage or ancestry was mixed with Moorish or other alien blood.

—HARRY WAIN, M. D., Mansfield, Ohio.



Ohioan Performs First U. S. Appendectomy

WILLIAM F. DAVIS

THE first appendectomy in the United States was performed by Dr. Randolf N. Hall, who was born at Eagleville, Ashtabula County, Ohio, April 2, 1844. The operation was an emergency procedure, and took place on the night of May 8, 1886 at the Roosevelt Hospital in New York City.

Although the place and date of birth of Dr. Hall are known, information about him is very sketchy, and completely lacking in places. Dr. Hall's parents apparently moved from Eagleville to Iowa when he was a young boy. Hall answered President Lincoln's first call for volunteers at the start of the Civil War, but was eight months short of the minimum age limit. However, the lad was accepted as a drummer boy on his second attempt to enlist. He participated in the Battle of Shiloh, April 6, 7, 1862, where he exchanged his drum for the rifle of a fallen comrade and fought in the ranks.

PRISONER OF WAR

Hall was later captured by Southern troops and remained a prisoner of war for eight months, at which time he was fortunate enough to be included in a prisoner exchange. After this exchange he rejoined the Northern troops at the siege of Vicksburg, and fought through the Mississippi campaign. When his term of enlistment expired, Hall reenlisted in the veteran corps of the Army of Tennessee, in 1864, and participated in several conflicts that year. During one of these he was again captured and endured a second imprisonment. He was presumably released from this second imprisonment upon the cessation of hostilities. He was finally mustered out of the army in 1866, after five years' service.

Hall returned to Iowa following his discharge and attended the College of Physicians and Surgeons at Keokuk, where he received his M.D. degree. This medical school later disappeared.

Submitted September 27, 1953.

The Author

● Mr. Davis, Ashtabula, Ohio, is a member of the Junior class of The Ohio State University College of Medicine.

After some years of practice in both Iowa and Kansas, Dr. Hall went to Chicago, and there attended Rush Medical College (now the University of Chicago) for two years. He left Rush in 1882 and practiced in Chicago for the next 18 years, until his death there on December 30, 1900, at the age of 56.

At the beginning of his Chicago career, Dr. Hall was a lecturer on anatomy and surgery in the College of Physicians and Surgeons, which was taken over by the University of Illinois in 1913. He was a member of the American Medical Association, the Chicago Medical Society, a president of the Pathological Society of Chicago, and he was on the staffs of Baptist, Mary Thompson, and St. Elizabeth Hospitals. In his later years, Dr. Hall was a professor in, and the president of, the Illinois Medical College, which was eventually absorbed by Loyola University.

Strangely enough, although the appendectomy in question was performed by Dr. Hall at Roosevelt Hospital in New York City, no explanation can be found as to why he was in that city. He could have been visiting there, teaching, or perhaps he practiced there for a short time.

At any rate, Dr. Hall attended a 17 year old Irish boy who was admitted to Roosevelt Hospital via the emergency room at 10:30 p. m., May 8, 1886. The boy had a history of a right oblique inguinal hernia since childhood, always reducible, and never having caused any trouble. Upon admission the boy stated that for two weeks he had passed no feces or flatus, and that three days prior to admission the hernia came down and

could not be reduced. Since that time he vomited almost constantly, and had constant and severe pain over the entire abdomen. The hernial sac, extending into the right inguinal canal, became red, swollen, painful and very tender. The boy's pulse was 120-140 upon admission, and very feeble. His respiration was shallow and he was dehydrated.

THE OPERATION

A diagnosis of probable strangulated hernia with gangrene and general peritonitis was made, and an operation was immediately undertaken, using ether anesthesia. Several times during the operation the patient collapsed and nearly died, and whisky was administered by hypodermic injection.

Upon opening the hernial sac and the peritoneal cavity, over a pint of foul-smelling pus was removed. The cecum was observed to be flush against the internal inguinal ring and the appendix, thickened and curled on itself, was noted at the bottom of the scrotal sac. Near the base of the appendix a ¼ inch perforation was seen.

Dr. Hall ligated the appendix at its base and removed it. The stub was disinfected with bichloride of mercury, but not sutured. No attempt was made to disinfect the peritoneal cavity. A drain was put in place and the abdominal incision was closed. The patient recovered nicely, and the sutures were removed in seven days. The final diagnosis was appendiceal abscess and peritonitis.

While Dr. Hall's operation was not a deliberately planned appendectomy, inasmuch as he undertook the procedure for the relief of a strangulated hernia, yet he nevertheless was the first man in the United States, of whom we have a record, to remove the appendix, and apparently the first one in the world to perform an appendectomy successfully — so that the patient recovered.

REFERENCES

1. (_____): Dr. Randolf N. Hall. Chicago Medical Recorder. Vol. XX, p. 202, 1901.
2. Hall, Randolf N.: Suppurative Peritonitis Due to Ulceration and Suppuration of the Vermiform Appendix; Laparotomy; Resection of the Vermiform Appendix; Toilette of the Peritoneum; Drainage; Recovery. New York Med. J., 43:662-663, 1886.
3. Kelley, Howard A.: A Cyclopedia of American Medical Biography. Vol. I, p. 375.
4. Roosevelt Hospital: Correspondence.
5. State University of Icwa: Correspondence.
6. University of Illinois: Correspondence.

Ludwig Jekel's Selected Papers, ($4.50. *International Universities Press, New York 11, N. Y.),* This is the first collected edition of Dr. Jekel's most significant papers in a belated tribute to one of Freud's earliest collaborators in psychoanalysis. This collection naturally contains those papers most frequently cited in the literature, and therefore, is a handy reference volume.

Addendum to Physicians and The Indian Wars

One of the physicians recorded in December, 1952, issue of *The Journal* in the article "Report of Surgeons of the Indian Wars," and reprinted in the commemorative pamphlet "Physicians and the Indian Wars," is Charles Watrous. *The Journal* is indebted to Dr. James J. Tyler, Warren, for the following additional information which he obtained from Colonel James R. Case, Bethel, Conn., historian of the Grand Masonic Lodge of Connecticut.

Charles Watrous was born in Colchester, Conn., April 25, 1769, the son of Dr. John Richards Watrous and his first wife, Jerusha Huntington. The elder Dr. Watrous was active in several Masonic bodies including the Knights Templars. Charles finished at Dartmouth College in 1789 and presumably studied with his father who always had a number of young assistants under his tutelage. He enrolled as a surgeon's mate in the 3rd Sub Legion February 23, 1793, and served with Wayne's Army. He died at Philadelphia May 11, 1798, while on a return trip from Natchez and according to Richard C. Knopf, author of the original article, was a suicide. His Masonic record is brief because of his being hurried through as a service man and his death which followed shortly afterwards. The records of Wooster Lodge show that he took his first Masonic work on January 30, 1798, taking the second degree on the same date and became a Master Mason on February 7, 1798.

Hepatorenal Glycogen Disease

In 1929, Von Gierke reported a clinical syndrome encompassing an enlarged liver, kidney, and other internal organs, due to excessive deposition of glycogen. To date there is a wide variation in the number of cases reported, ranging from 50 to over 200, depending upon the diagnostic criteria employed.

Mason and Anderson list a detailed plan for classification of the glycogen storage diseases. They consider the deposition of glycogen in the liver necessary for the diagnosis of true Von Gierke's disease.

At least two distinct types of glycogen storage disease have been reported, the cardiac and the hepatic type. Di Sant' Agnese, Anderson, and Mason believe that these two types never co-exist. The cardiac type has widespread involvement of tissues with glycogen, associated with an enlarged heart, and with death usually occurring in the first year of life. In the hepatic type, excess glycogen deposits are usually limited to the liver and kidneys.—Anthony J. Richtsmeier, M. D., and John Allen, M. D., Madison: *Wisconsin M. J.*, 52:593, November, 1953.

Proceedings of The Council . . .

Heavy Docket Considered at Meetings, December 11 and 12; Plans For Coming Year Discussed; Committee Reports Received; Budget Adopted

REGULAR meetings of The Council of the Ohio State Medical Association were held in the Columbus office on Saturday evening, December 12, and Sunday, December 13, 1953. All members of The Council were present. Others attending were: Dr. Jonathan Forman, Editor of *The Ohio State Medical Journal*; Mr. Wayne Stichter, Toledo, legal counsel; and Messrs. Nelson, Saville, Page and Moore.

On **motion** duly made, seconded and **carried**, the minutes of the meetings of The Council held on October 3-4, 1953, at Granville **were approved.**

MEMBERSHIP STATISTICS

The following information on membership was submitted by the Executive Secretary:

The Ohio State Medical Association membership: As of December 10, 1953, the total membership of the Ohio State Medical Association was 8,046, the largest in its history, compared to a total membership at the end of 1952 of 7,806. The 8,046 members consisted of 7,704 dues-paying members; 185 in military service and exempt from the payment of dues; and 157 exempt from the payment of dues because of retirement due to age or disability.

A. M. A. membership as of December 10, 1953, 6,926 of the 8,046 members of the State Association were members of the American Medical Association, compared to 6,442 at the end of 1952. Of the 6,926 A. M. A. members, 6,393 are dues-paying members; 156 exempt from the payment of dues due to military service; and 377 holding membership in the A. M. A. without the payment of dues under the exemption for age or retirement. Of the total membership of the State Association on December 10, 84.3 per cent were members of the American Medical Association.

MILITARY WAIVER

The following policy with respect to waiver of 1954 dues for members entering military service was adopted:

"1. State Association dues for 1954 shall be waived for members now on active military duty on a temporary basis and as a result of the present national emergency.

"2. State Association dues for 1954 shall be waived for physicians who were members of the Association in 1953 and who enter active military service during the calendar year 1954 before the payment of 1954 dues.

"3. A refund of membership dues will not be made if a member enters military service in 1954 after his 1954 dues are received at the Columbus office of the Association.

"4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions."

AMENDMENTS APPROVED

Amendments adopted on October 24 by the Clark County Medical Society to the Constitution and By-Laws of that society were reviewed by The Council. On **motion** duly made, seconded and **carried**, the amendments **were approved** as submitted. Amendments adopted on November 20, 1953, by the Van Wert County Medical Society to the Constitution and By-Laws of that society **were approved** as submitted, on **motion** duly made, seconded and **carried.**

The Executive Secretary was instructed to advise all County Medical Societies of amendments which had been adopted by several County Medical Societies and approved by The Council, regarding the establishment of an associate membership in order to take care of new physicians entering a county prior to the time they are accepted into active membership, and to suggest to County Medical Societies that they consider the advisability of so amending their by-laws.

ANNUAL MEETING

The Executive Secretary reviewed plans to date for the 1954 Annual Meeting.

The Council approved the creation of a new section, namely, Section on Neurological Surgery, and designated Dr. Harry E. LeFever, Columbus, as chairman, and Dr. Charles W. Elkins, Cleveland, as secretary.

OFFICIAL POLICY TO BE CITED

A communication from a county society, asking for advice and information regarding a resolution adopted by the Summit County Medical Society, was considered. The resolution of the Summit County Medical Society stated that the society "regards the employment of physicians by hospitals on a salary only basis with a charge being made by such employer-hospitals for the services of such employed physicians as contrary to the standards of practice of the medical profession and does hereby censure any such agreement."

The Executive Secretary, on **motion** made, seconded and **carried**, was instructed to advise the society of the official policy laid down by the Judicial Council of the American Medical Association on this general question and to point out to him that erroneous publicity had been given

in some newspapers regarding changes in the agreements between the A. M. A. and the American Hospital Association on physician-patient relations.

POLIO PROGRAM

The Council was advised that preliminary plans had been made for Ohio to participate in the national polio prevention test program which will be initiated shortly after the first of the year throughout the country by the National Foundation for Infantile Paralysis in cooperation with state public health agencies. It was pointed out that the vaccination program would be carried on in certain communities of Ohio among second grade school children whose parents request that the vaccine be administered to their child. Dr. John D. Porterfield, Ohio Director of Health, will request local health commissioners in the designated areas to administer the trial vaccine program and will seek the assistance and cooperation of local physicians, nurses, and school officials. The Council, on **motion** duly made, seconded and **carried**, voted the cooperation and assistance of the Ohio State Medical Association and expressed the hope that County Medical Societies and individual physicians in the Ohio areas selected for participation in the program would give their help and cooperation. (See Page 60 for detailed story.)

V. A. FEE SCHEDULE

The Council reviewed correspondence from the Veterans Administration, Washington, pertaining to action on proposed changes in the fee schedule appearing in the agreement between the Veterans Administration and the Ohio State Medical Association governing the Ohio home town care for veterans.

Dr. Paul A. Davis, Akron, the President, pointed out that many of the revisions suggested by the Ohio State Medical Association had been approved by the Veterans Administration and that action by The Council in approving or disapproving the changes accepted by the Veterans Administration is necessary. On **motion** duly made, seconded and **carried**, The Council approved changes as approved by the Veterans Administration and authorized Dr. Davis and the Executive Secretary to so advise the Veterans Administration. (See Page 65 for detailed story.)

Information obtained from the regional offices of the Veterans Administration in Cleveland and Cincinnati for the fiscal year ending June 30, 1953, which had been requested by The Council, was submitted by the Executive Secretary. The data included statistics on the number of veterans receiving care from fee-basis physicians; the number of physicians receiving payment under the home-town program; the amounts paid to fee-basis physicians and to private hospitals; and the number of veterans receiving treatment from out-patient clinics operated by the regional offices. (See Pages 65 and 66 for detailed story.)

W. C. FEE SCHEDULE

Reporting for the Committee on Industrial Health and Workmen's Compensation, the Executive Secretary advised The Council that the Ohio Industrial Commission has taken no action, as yet, on the proposed changes in the Workmen's Compensation Medical and Surgical Fee Schedule submitted to the Commission by the Association on August 18, 1953. He reported that the chairman of the committee had been advised that the changes are now being studied by the actuarial and auditing departments of the Commission. The Chairman of the Committee and the Executive Secretary were instructed by The Council to communicate with the Commission urging prompt action on the recommendations.

The Council, by official action, voted its cooperation to the new medical director of the Commission, Dr. A. L. Kefauver, successor to Dr. Robert Andre, who has taken a position as medical director of the atomic plant in Pike County which is being operated for the United States Government by the Goodyear Tire and Rubber Company.

HOSPITAL ACCREDITATION

Dr. G. A. Woodhouse, Pleasant Hill, reviewed discussions which took place at the recent meetings of the House of Delegates in St. Louis on the hospital accreditation program and the activities of the National Committee on Hospital Accreditation. He advised The Council that shortly after the first of the year his Committee on Hospital Accreditation would meet for the purpose of drafting a letter of inquiry to secure information and data as to the effect of the hospital accreditation program on Ohio hospitals. He stated that after securing that data the committee would make a complete study of it and would submit recommendations for consideration and action by The Council.

A. M. A. SESSION

Dr. Davis, Dr. Woodhouse and the Executive Secretary reviewed briefly actions taken by the House of Delegates of the A. M. A. at the St. Louis meeting. It was pointed out that Ohio's delegates served on several of the important reference committees and that at the present time a large number of Ohio physicians are holding important positions on councils, boards or special committees of the A. M. A.

BLUE CROSS PROBLEM

Dr. E. A. Artman, Chillicothe, reviewed for The Council the status of the differences which had arisen between the Central Ohio Psychiatric Society and Central Hospital Service (Blue Cross). He pointed out that the Board of Trustees of Central Hospital Service had rejected a

request that the Blue Cross contract in Central Ohio cover persons suffering from nervous and mental diseases for the reasons (1) that some of the hospitals do not wish to "go into nervous and mental work"; and (2) the financial problem of including additional services in the contract. It was the opinion of The Council that no additional action could be taken by The Council at this time, but that the matter should be left pending for future study.

NO MORE TOBACCO ADS

Attention was called to the fact that the American Medical Association has decided to discontinue tobacco advertisements in all publications of the A. M. A. and exhibits by tobacco concerns at the annual and interim sessions of the A. M. A. After a discussion, The Council instructed the managing editor and the business manager of *The Ohio State Medical Journal* not to accept new contracts for tobacco advertising in *The Ohio State Medical Journal* and to discontinue the sale of exhibit space at annual meetings of the Ohio State Medical Association after the 1954 Annual Meeting.

A. M. E. F. CAMPAIGN

Mr. George H. Saville, Director of Public Relations, reported for Dr. Wm. M. Skipp on the progress of the Ohio campaign in behalf of the American Medical Education Foundation. He said that the A. M. E. F. has received $18,126 from 360 subscribers in Ohio as of November 30, 1953, which represents a considerable increase over the 1952 total of $13,177 from 265 subscribers.

P. G. MEETING

Dr. C. L. Pitcher, Portsmouth, reported on the Ninth District Postgraduate Program given at Jackson on December 3. This was a program sponsored jointly by the Ninth Councilor District of the Ohio State Medical Association and the ninth councilor district of the Ohio Academy of General Practice. Program details were handled by Dr. Pitcher and Dr. Herbert Chamberlain, McArthur, assisted by the Columbus Office. Dr. Pitcher reported that 52 physicians of the district had attended the program, which was presented by members of the faculty of the Ohio State University College of Medicine. He stated that it was the opinion of the physicians who had attended that future meetings of this kind should be held.

SCHOOL HEALTH ACTIVITIES

Mr. Hart F. Page reported on a meeting of the Committee on School Health, held in Columbus on Wednesday, November 18. (See Page 61 for detailed story.) The committee made the following recommendations:

1. That additional school health guides should not be prepared and distributed until after the Ohio Conference on Physicians and Schools being planned for May 11-13, 1954, at Lake Hope, Zaleski, Ohio, and joint conferences with school officials and teachers on subjects to be covered.

2. That the committee publish a booklet for county medical society school health committees, outlining the functions of such committees and giving suggestions as to techniques and methods of operation.

3. That the committee be reorganized along councilor district lines so that one member of the committee will be available to work closely with school health committees of all county medical societies of each district.

Mr. Page also reported that the committee had met jointly at a dinner session in the evening with members of the State Planning Committee for state health education and others representing the education profession, at which time questions of mutual interest were discussed and preliminary plans made for the Ohio Conference of Physicians and Schools next Spring.

HANDLING GRIEVANCES

The Executive Secretary submitted to The Council a statement of suggested policies and procedures on the handling of grievances, including specific recommendations on procedures which might be followed by Grievance Committees of County Medical Societies. This had been requested by The Council at its last meeting. The Council approved the principles and procedures recommended and instructed the Columbus office to make a copy available to officials of all County Medical Societies.

POLICY ON CANCER REPORTING

Dr. C. L. Hudson, Cleveland, discussed with The Council a request from the Cleveland Academy of Medicine that the Ohio State Medical Association consider the feasibility, advisability and benefits of legislation to make cancer a reportable disease. The official previous actions of The Council and the Committee on Cancer on this question were summarized for the information of The Council. By official action, The Council expressed the opinion that no new action should be taken at this time. It instructed the Executive Secretary to provide Dr. Hudson with a memorandum of actions taken by The Council and the committee to date so that he could properly advise the Board of Directors of the Cleveland Academy of Medicine of the policy of the Association on this question.

ACCIDENT PREVENTION

A communication from Dr. Robert H. Kotte, Cincinnati, chairman of the Accident Prevention Committee of the Ohio Chapter of the American Academy of Pediatrics, was reviewed. Dr. Kotte requested the Ohio State Medical Association to be a co-sponsor of a state conference on child safety to be held in the Fall of 1954. By official action, The Council voted the cooperation of the State Association and instructed Mr. Page

to represent the Association when the committee meets to plan for the conference.

BUDGET FOR 1954

At an executive session The Council considered the annual report of the Committee on Auditing and Appropriations and the Treasurer. By unanimous action, The Council approved the report and recommendations of the committee, including the following budget for 1954:

The Ohio State Medical Journal		$27,500.00
Executive Secretary, Salary		13,260.00
Executive Secretary, Expense		2,000.00
Stenographic and Clerical Salaries		25,580.00
President, Expense		1,000.00
Council, Expense		3,000.00
American Medical Association Delegates		5,000.00
Department of Public Relations (see below)		35,820.00
Director, Salary	$11,320.00	
Director, Expense	2,000.00	
Asst. Director, Salary	6,600.00	
Asst. Director, Expense	2,000.00	
Exhibits and Newspaper Publicity	2,000.00	
Literature	5,000.00	
Postage	2,000.00	
Supplies	500.00	
Miscellaneous Activities	5,000.00	
Committee on Education		250.00
Committee on Public Relations and Economics		500.00
Committee on Scientific Work		500.00
Committee on Auditing and Appropriations		650.00
Committee on Blood Banks		200.00
Committee on Chronic Illness		750.00
Committee on Industrial Health		500.00
Committee on Medical Care of Veterans		200.00
Military Advisory Committee (see below)		3,500.00
Chairman, Salary	$3,000.00	
Committee, Expense	500.00	
Miscellaneous Committees		500.00
Committee on Rural Health		2,000.00
Rural Medical Scholarships		2,000.00
Committee on School Health		1,000.00
Annual Meeting		20,000.00
Conference of County Society Pres.-Secretaries		2,000.00
Employees Retirement Fund		3,900.00
Insurance and Bonding		2,600.00
Postage		2,000.00
Professional Relations Activities		6,000.00
Rent		7,349.52
Stationery and Supplies		3,000.00
Telephone and Telegraph		2,500.00
Legal Expenses		2,500.00
Contingent Unassigned		14,140.48
TOTAL		$192,300.00

FEDERAL-STATE RELATIONS

A request from the Ohio Chamber of Commerce that the Ohio State Medical Association be represented on a committee which it is forming to study problems of federal-state relations, was read and discussed. Mr. Saville was designated by The Council to represent the State Association on this committee.

PROBLEMS OF THE AGING

The Executive Secretary reported that the Association had been requested to cooperate in planning for a conference on problems of the aging and to participate in such conference. The conference will be jointly sponsored by the Ohio Citizens Council for Health and Welfare and the Ohio State University. He advised The Council that he had attended a meeting recently at which plans for the state-wide conference had been discussed. By official action, The Council voted the cooperation of the Ohio State Medical Association and instructed the Executive Secretary to represent the Association at future conferences on this matter.

JOINT COMMISSION

A communication from the American Medical Association, requesting the formation in Ohio of a Joint Commission for the Improvement of the Care of the Patient, was read and discussed. Action was deferred pending the securing of additional copies of the material for distribution to members of The Council for study prior to the next meeting of The Council.

REED - JENKINS BILLS

The attention of The Council was called to the fact that an effort would be made to have the U. S. Congress at its 1954 session take favorable action on the Reed-Jenkins bills relating to voluntary pension plans for self employed persons, including physicians. The Council, by official action, reaffirmed its approval of this proposed legislation and instructed the Executive Secretary to so advise Congressman Thomas Jenkins, Congressman from the Tenth Ohio District, one of the co-authors of the proposed legislation, and to respectfully request Mr. Jenkins to request early action by the Congress.

DR. PAUL THANKED

The Council was advised that Dr. R. C. Paul, Wooster, aged 92 years and 6 months, has just retired as secretary-treasurer of the Wayne County Medical Society after approximately 30 years of service in that office. The Council adopted a motion thanking Dr. Paul for his many years of faithful and efficient services and expressing appreciation for the cooperation and assistance he has given to the officials of the Association and the Columbus Office staff.

Attest: CHARLES S. NELSON,
Executive Secretary.



These Two Leading Columbus Hotels—

The Neil House and The Deshler - Hilton Hotel Will Furnish Meeting Places And Exhibit Space for the 1954 Annual Meeting of the Ohio State Medical Association April 12-15, 1954

1954 Annual Meeting . . .

This Year's Program Will Coordinate Specialty Society Programs with Other Features; Outstanding Guest Speakers Will Present Discussions

Specialty Society Day—An innovation of this year's meeting will be coordination of Specialty Society programs with other events of the Annual Meeting. Monday, April 12, has been set aside for these Specialty groups to work up their own programs as best fits the needs of their members. Tuesday's program has, as nearly as possible, been geared to these specialty meetings so that those who can spend only a minimum of time at the meeting may put that time to best use.

As this issue of *The Journal* went to press, meetings had been scheduled on Monday for the following organizations: Ohio Chapter, American Academy of Pediatrics; Ohio State Surgical Society; American Academy of Obstetrics and Gynecology; Columbus Obstetrical and Gynecological Society; Ohio Academy of General Practice.

Specialty Section Meetings—Tuesday and Wednesday mornings are devoted to these meetings conducted by specialty sections for the benefit of general practitioners and other physicians in all branches of practice. Outstanding nationally known speakers from other states as well as from Ohio will take part in these programs.

General Sessions—On Tuesday and Wednesday afternoons and Thursday morning are scheduled General Sessions during which subjects of current interest to all physicians in practice will be presented by outstanding guest speakers.

Allied Health Organizations—Watch for announcement of these special group meetings on Thursday afternoon.

Scientific and Technical Exhibits—Ample periods have been allotted for the purpose of visiting the exhibits, which have proven main features of previous programs. The Scientific Exhibit will be located in the Deshler-Hilton Hotel while the Technical Exhibit will be in the Neil House. Only a half square separates these downtown hotels so that virtually no time will be lost between them.

The Annual Banquet—Wednesday evening as usual has been set aside for this social event which provides a welcome pause between busy sessions. Instructions on how to make reservations will be sent to members.

House of Delegates—The policy-making body of representatives from each County Society will meet twice during the Annual Meeting—on Monday evening and on Thursday morning. Those attending in an official capacity will be served dinner and breakfast respectively before these meetings. Any member is welcome to listen in on business sessions.

Conference of County Society Officers—An excellent program is in store for this conference on Tuesday afternoon and evening, April 13. The conference will include a buffet supper prior to the evening session.

Guest Speakers—Watch for names of outstanding guest speakers who have been invited to address sessions at the Annual Meeting. Top level figures in many branches of medical practice will be on hand to present their subjects before specialty section programs and general sessions. These out-of-state medical men coupled with the array of picked speakers from Ohio will make the 1954 Annual Meeting a "must" on the agenda of all practicing physicians.

Are You Planning . . .

to attend the 1954 ANNUAL MEETING OF THE OHIO STATE MEDICAL ASSOCIATION in COLUMBUS, APRIL 12-15? If so, it is an excellent plan to make HOTEL RESERVATIONS well in advance to assure the best accommodations. This list of leading downtown Columbus hotels is given for your convenience. It isn't too early to clip the coupon at the bottom of this page and mail it to the hotel of your choice.

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BEDS
NEIL HOUSE	$5.50-7.00	$8.00-10.00	$10.00-13.00
DESHLER-HILTON HOTEL	$5.00-9.00	$9.00-13.50	$ 9.50-14.50
HOTEL FORT HAYES	$5.50-8.00	$8.50-10.00	$10.00-11.00
SENECA HOTEL	$4.00-6.00	$6.00- 8.00	$ 8.00-10.00
SOUTHERN HOTEL	$5.00-6.00	$6.50- 8.50	$10.00-11.00
HOTEL VIRGINIA	$4.50-5.00	$7.50- 8.00	$ 8.00- 9.00
HOTEL CHITTENDEN	$3.50-4.00	$5.00- 6.75	$ 6.75-10.50

Persons who desire suites or other additional accommodations are advised to specify their needs to the hotel of choice.

(All rates subject to change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 12, 13, 14, 15, 1954, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price .....

☐ Twin Bed Room with Bath ☐ Additional Accommodations (Specify)

Arriving April..... at .....A.M.....P.M.

PLEASE VERIFY MY RESERVATION

Name .....

Address .....

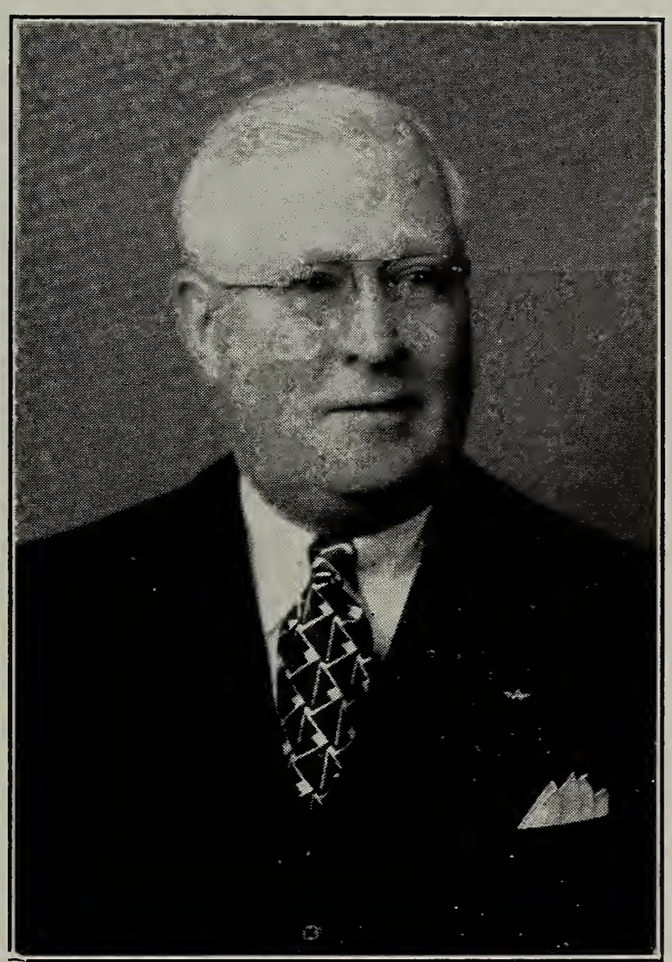
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Message From The President

ADVENT of the New Year offers an opportunity for me, speaking personally and in behalf of the other officers and the Councilors, to extend greetings to all members of the Association; to review briefly some of the Association's activities since the 1953 Annual Meeting; and, to take a quick look at the immediate future.

The Association ended the year with the largest membership in its history—8058. Of that number, 6934 were active members of the American Medical Association, a substantial increase over 1952.

During the year, the Committee on Industrial Health and Workmen's Compensation held no less than nine meetings, during which the Workmen's Compensation Medical Fee Schedule was analyzed and numerous suggested revisions submitted to the Ohio Industrial Commission. The Commission has our suggestions under advisement.



PAUL A. DAVIS, M. D.

Study of the medical programs of the State Public Assistance program and of the Division of Aid for the Aged was initiated by the Committee on Public Relations and Economics. A report is being prepared and will be used by the committee as the basis for conferences with officials of both agencies in an effort to improve these programs.

Two new committees were set up. One of these will make an analysis as to how the new hospital accreditation program is affecting Ohio hospitals. After completing that study the committee may have some specific changes to recommend for consideration by The Council and submission by it to the national accreditation body and the A. M. A.

The other new committee, known as the Committee on Maternal Health, charged with the responsibility of studying the feasibility of setting up a state-wide committee whose function would be to study, analyze and report on all maternal deaths in Ohio and to carry on an educational program on this subject.

Work of our Committee on Legislation and the Columbus Office staff during the 1953 session of the Ohio General Assembly and the U. S. Congress is well known to the membership. Their efficiency is revealed by the fact that no legislation actively opposed by the medical profession was enacted by the state legislature and a number of bills supported by the profession became laws. Close and friendly liaison was established with most of Ohio's Congressmen.

Our Committee on Rural Health cooperated with other groups in sponsoring a number of important regional rural health conferences throughout the state. The Committee on School Health met to plan some new activities during the coming year. One of these will be active participation in an Ohio Conference for Schools and Physicians, patterned after the national meeting sponsored by the A. M. A., which will be held next Spring at Lake Hope.

Several revisions in the medical fee schedule of the Ohio Veterans Medical Care Program were made by the Veterans Administration as a result of recommendations submitted by our Committee on Medical Care of Veterans.

The Committee on Chronic Illness, Committee on Mental Health and Cancer Committee, jointly, are planning to hold conferences in the near future with officials of the Department of Public Welfare. The subjects to be considered will in-

clude plans of the department for enlargement of the state's program for hospitalization of the mentally ill, those with chronic illnesses and the aged; policies and procedures of the department governing the operation of the state hospitals and the out-patient clinics; and similar matters.

The Medical Advisory Committee to Selective Service in cooperation with the Columbus Office has continued to give Selective Service and the Department of Defense valuable help in securing an adequate number of medical officers. At the same time the committee, assisted by the Physicians' Placement Bureau of the Association, has endeavored to protect small areas by having physicians eligible for military service deferred until replacements can be secured, and by carrying on an active campaign to place physicians in such communities and in areas in need of additional physicians.

PUBLIC RELATIONS

For several years, one of the most active departments of the Association has been the Department of Public Relations. It has continued with its fine work. Large quantities of literature have been provided for physicians and the public generally. Exhibits have been shown at many public gatherings. The director and his assistant have addressed many meetings of both physicians and laymen and have established a close working relationship with representatives of the press, radio and television. Much assistance has been given to public relations committees of many county medical societies.

Plans are being completed by the Committee on Scientific Work, assisted by the officers of the Scientific Section, for the 1954 Annual Meeting program. The meeting will be held April 12-15 in Columbus. A fine program of postgraduate education for all members has been arranged.

Several new features have been initiated by *The Journal*, which continues to be "must" reading on the part of all members. The *OSMAgram*, in the opinion of many members, improves with age and gives members a resumé of what's going on in a concise and interesting manner.

The Council has held four sessions since the 1953 Annual Meeting. The docket at each session carried many items of special importance to the membership. The Council's action on these have been digested in *The Journal.*

A LOOK AHEAD

What about 1954?

Many of the activities which have been listed will be continued, as they are a part of the regular program and services of the Association. Work will have to be completed on some of the special projects which have been started. Also, keep in mind that Congress will be in session during most of 1954. This means that it will be necessary for physicians to be in constant touch with their respective Congressmen. Moreover, 1954 will be an important election year. Doctors as citizens should be prepared to take an active part in the pre-primary and pre-election campaigns in behalf of the candidacies of qualified candidates.

When I took office at the 1953 Annual Meeting in Cincinnati, I outlined a program of suggested activities and objectives for the Association. That program, I believe, might well be a guide for all of us during the New Year. It is as follows:

TWELVE VITAL POINTS

1. Practice good ethical medicine.
2. Clean our own house by disciplining those M. D.'s, few in number, who are tarnishing the reputation of the whole profession by their unethical acts.
3. See that the public is protected so that they can always obtain the services of good physicians.
4. Revitalize our county societies and make them leaders in their communities on all health and civic movements where the health and care of the public is concerned.
5. Work with rural communities to establish facilities for physicians, so that a better distribution of physicians and medical care is available.
6. Devote some of your time to public-patient relationship.
7. Extend public health coverage to areas lacking it and give good medical care to the indigent and chronic invalid.
8. Continue to give active support to our voluntary medical insurance program so that it can provide benefits for many more citizens of Ohio.
9. Work for better care of the physically handicapped and then return to self-support.
10. Inculcate the newly-trained physician in the traditions and ethics of good medicine.
11. Support any good ethical medical activity if it is of value to the health and welfare of the public.
12. And finally, be more active in your county, state and national medical organizations.

In conclusion, may I extend to all members the best wishes of the officers and Councilors and appreciation for your loyal support. You are the Ohio State Medical Association. Its continued success is insured if you will give it your active support, individually and collectively.

Sincerely yours,

PAUL A. DAVIS, M. D., *President.*

Civil Service Openings

The United States Civil Service Commission has announced a new Medical Officer examination for filling the positions of rotating intern, $2,800 a year, and resident in training in psychiatry and in neurology, $3,400 to $4,200 a year, in St. Elizabeths Hospital in Washington, D. C. Appointments are to begin on July 1, 1954.

Special Train to 'Frisco . . .

Reservations Now Being Accepted for Ohio State Medical Jaunt To the West Next June; Great Itinerary Arranged for Ohio Party

RESERVATIONS can now be made by writing to Executive Secretary Charles S. Nelson of the Columbus Office for the super-duper Ohio State Medical Special Train trip to the West next June when the American Medical Association meets in San Francisco.

Leaving Chicago on June 12, the Ohio party of members of the Association and members of their families aboad an all-room special train will travel to San Francisco



ROUTE OF O. S. M. A. SPECIAL TRAIN, WITH SCENE FROM GLACIER NATIONAL PARK IN BACKGROUND

by way of Denver, the Royal Gorge, Salt Lake City, Los Angeles and Yosemite National Park. There will be plenty of sightseeing and fun in Salt Lake City, Los Angeles and Yosemite National Park.

After the A. M. A. meeting in San Francisco, the O. S. M. A. Special will pull out of the Golden Gate City on June 25. En route home, the party will stop at Portland for the famous Columbia River Highway drive, including Multnomah Falls and Bonneville Dam. From there, the train will travel through the very heart of the Northwest Rockies. There will be three days and three nights at grand and glorious Glacier National Park. The party will arrive at Chicago on July 3.

The cost of the all-expense trip will be approximately $500 per person, depending

on the kind of Pullman space selected and **exclusive** of meals and sightseeing at Los Angeles and San Francisco, one meal in Portland and roundtrip rail and Pullman fare between home city and Chicago. Everything else, even tips, will be included in the all-expense cost.

Write Mr. Nelson for complete details. He will secure hotel space in San Francisco at either the Drake-Wiltshire or Plaza Hotel for members of the party who want him to do so. A booklet outlining the trip, costs, how to make reservations, etc., has been prepared and will be mailed to those interested.

Polio Vaccination Program . . .

Areas In Ohio Will Be Picked As Part of Nation-Wide Move To Test Effectiveness of New Vaccine; Porterfield To Direct Details in State

THE Ohio State Medical Association will cooperate in the polio prevention test program which will be carried on in selected areas of Ohio next Spring.

The Council on December 12 pledged the assistance of the Association and will request medical societies and physicians of the areas selected for the test program to do likewise.

The vaccination of second grade school children in the selected areas of the state, whose parents request the vaccination, will be part of the largest test program of its kind in medical history. The purpose is to help determine the effectiveness of a new trial vaccine in preventing paralytic polio. It is anticipated that the vaccine will be given to at least 500,000 and perhaps 1,000,000 second-grade children in 200 communities in the nation.

The nation-wide program will be carried on jointly by the National Foundation for Infantile Paralysis and state health departments with the cooperation of local health officers, local physicians, nurses, school officials and members of local chapters of the Foundation.

DR. PORTERFIELD TO DIRECT

Dr. John D. Porterfield, Ohio director of health, will direct the program in Ohio. He is a member of a special committee of the State and Territorial Health Officers Association which has taken a very important part in the planning for the program.

The date for start of the program in Ohio has not as yet been determined. The nation-wide program will start early in February in the southern states. It will be completed everywhere by June 1.

Ohio areas in which the tests will be given have not been selected. An announcement of communities selected will be made by Dr. Porterfield early in January. A specific formula, based on past polio records of communities, will be used in selecting the Ohio areas where the program will be instituted.

After an area has been selected, the local health commissioner will be asked to direct administrative details. The members of the local chapter of the polio foundation will cooperate, especially in the keeping of records and follow-up checks during the ensuing polio season.

The National Foundation will provide the trial vaccine without cost. Supplies and equipment will be sent to Dr. Porterfield who will facilitate the reshipment to the selected counties.

Each second grade student in the designated areas, whose parents request it, will receive three shots in the arm in the trial study. The first two will be one week apart. The third, or booster shot, will be given at least four weeks after the second. The results will be checked during the remainder of 1954 to see how effective the vaccine is in preventing polio.

Dr. Jonas E. Salk, Pittsburgh, developed the new trial vaccine. Every batch will be subjected to three rigid, scientific tests for safety before it is used. These tests will be made by the Laboratory of Biologics Control of the National Institutes of Health, a unit of the U. S. Public Health Service, by Dr. Salk's laboratories at the University of Pittsburgh, and by each commercial laboratory producing the vaccine.

The program has received the endorsement of the American Academy of Pediatrics and of nine different national organizations in the field of education.

Several special medical and scientific advisory committees have studied the data on the vaccine and the work done in the Pittsburgh area by Dr. Salk. They have decided that they believe the vaccine is now safe for use and ready for field trials. On the advice of these committees, special arrangements have been made for numerous safety tests on each batch of the vaccine before it is distributed for use.

As details for carrying on the program in the Ohio areas selected for the test are developed, information will be published in *The Journal.*

School Health . . .

Association Is Host to State Planning Committee for Health Education; Group Lays Plans for First Ohio Conference on Physicians and Schools

THE Committee on School Health of the Ohio State Medical Association was host November 18 to members of the State Planning Committee for Health Education and members of the education profession.

These groups conferred at a dinner meeting in Columbus regarding plans for the first Ohio Conference on Physicians and Schools, which is scheduled May 11-13, 1954, at Lake Hope Lodge, Zaleski. This conference will add state and local emphasis to the National Conferences on Physicians and Schools sponsored every two years by the American Medical Association at Highland Park, Illinois.

The primary purpose of the first Ohio conference will be to develop a working relationship between physicians and educators on school problems by promoting understanding; clarifying school health policies and delineating responsibilities.

TEAMS FROM SELECTED AREAS

It was decided that this would be best accomplished by inviting to the conference, teams from selected areas, including a school superintendent, a physician representing the medical society, nurse, teacher, and public health officer.

By resolution, those attending the meeting requested that Mr. Sewall O. Milliken, chief of the Division of Health Education for the Ohio Department of Health and chairman of the State Planning Committee for Health Education, appoint a committee on arrangements for the scheduled Conference on Physicians and Schools, and that this committee be composed of a cross-section of the professions represented at the planning meeting.

At a meeting held the afternoon preceding the dinner, the Committee on School Health of the Ohio State Medical Association discussed plans for 1954.

It was decided to issue additional numbers in the *School Health Guide* Series following the Ohio Conference on Physicians and Schools. It was the opinion of the committee subjects for the next three guides could best be determined by the needs expressed at the conference.

The publication of a booklet for county medical society school health committees, outlining the functions of such committees and giving suggestions as to techniques and methods of operation, was authorized.

The committee voted to recommend to The Council that the Committee on School Health be reorganized along Councilor District lines, in order that at least one member will be available to service the county medical society school health committees of each district.

In the program following the dinner meeting with the health educators, Dr. Homer B. Thomas, Gallipolis, chairman of the Committee on School Health of the Ohio State Medical Association, welcomed the group and introduced the members of his committee and Mr. Milliken. Mr. Milliken presented the members of the State Planning Committee for Health Education and guest educators.

Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, was introduced and explained why the Association had called the meeting. Mr. Hart F. Page, secretary to the Association's Committee on School Health, outlined the origin and objectives of the committee.

An address on "Important Considerations for Conference Planning," was presented by Dr. Donald A. Dukelow, consultant on health and fitness, Bureau of Health Education, American Medical Association. Dr. John D. Porterfield, Ohio Director of Health, discussed "School Health in Ohio Today," and told of the history and development of the State Planning Committee for Health Education.

Mr. Robert Lucas, Ohio Education Association, spoke on "The Role of Educational Organizations and Agencies in School Health Activities."

COMPOSITION OF PLANNING COMMITTEE

The State Planning Committee for Health Education is composed of representatives from the Ohio Department of Health, Ohio Department of Education and Ohio Division of Mental Hygiene; the Health Coordinators from the five state universities; the Health Education Consultants from the five consultant districts of the Ohio Department of Health and a representative each from the Ohio State Medical Association; the Ohio State Dental Association, and others.

The primary purpose of the Committee is to encourage state level voluntary efforts to coordinate health education activities of the associations and official agencies.

O. S. M. A. COMMITTEE

Members of the Committee on School Health of the Ohio State Medical Association present were: Doctor Thomas, and Doctors Charles T. Atkinson, Middletown; Walter Felson, Greenfield; T. L. Light, Dayton; Harold C. Messenger, Sr., Xenia; Margaret O'Neal, Zanesville; J. M. Painter, Kent; J. W. Wilce, Columbus; Carl A. Wilzbach, Cincinnati; and Thomas E. Shaffer, Colum-

bus. Also, from the Association were Mr. Nelson and Mr. Page.

Members of the State Planning Committee for Health Education present were: Mr. Milliken, and the following members of the organization: Doctor Porterfield; John Louis, Ohio Tuberculosis and Health Association; Helen Massengale, Ohio Department of Health; Izola Williams, Ohio Department of Health; Marjorie Watson, Division of Mental Hygiene; Sam Cooper, Bowling Green State University; Joseph Trepp, Ohio University; P. C. Bechtel, Ohio Department of Education; George Eagle, Ohio Department of Health; Doctor Harry Millhoff, Ohio Department of Health.

Doctor Margot Hartmann, Ohio Department of Health; Ray Lenart, Ohio Department of Health; Paul Schuster, Ohio Department of Health; Florence Fogle, Ohio State University; Lillian Derflinger, Ohio Department of Health; and Frances Williamson, Ohio Department of Health.

Other guests were: Doctor Dukelow; Mr. Lucas; Watson Dersham, Cincinnati Health Department; Jack Rhoades, Ohio University; Frank Ballanger, Kent State University; Gertrude Eppler, Bowling Green State University; Doctor Wesley Cushman, Ohio State University; Edwin Kregenow, Cleveland Board of Education; Marjorie Patten, Cleveland Health Department; Matt Resick, Kent State University; and Ralph Ely, Wayne County School Superintendent.

Dr. Krusen Gets National Physician's Award

Dr. Frank H. Krusen, of the Mayo Clinic, who is chairman of the A. M. A. Council on Physical Medicine and Rehabilitation, was recently named to receive the Physician's Award by the President's Committee on Employment of the Physically Handicapped. The announcement was made by Vice Adm. Ross T. McIntire, committee chairman.

Dr. Krusen was the nominee from Minnesota for the award by unanimous choice of the Minnesota Governor's Advisory Committee on Employment for Physically Handicapped Persons, and was selected for his work in teaching physical medicine to other doctors. A part of his pioneering work in this field was his contribution to the development and construction of a new rehabilitation center at the University of Minnesota. When completed this center will assure continuous postgraduate training in physical medicine and rehabilitation.

Dr. Krusen will receive the award at the annual meeting of the Congress on Industrial Health at Louisville, February 23-24.

Dr. Krusen was chosen from a group of nominees from various states. Ohio's nominee, selected by the Ohio Inter-Agency Employ the Physically Handicapped Committee, was Dr. Claude S. Perry, of Columbus.

Ohioans Take Part in Public Relations Conference in St. Louis

Major topics for consideration at the Sixth Medical Public Relations Conference of the American Medical Association, held November 30, were "Making a PR Program Work"; "Selling Our Economic System: How Others Do It"; and "Mending Our PR Fences."

The conference was held in St. Louis, just prior to the Midwinter Clinical Session and Interim Session of the House of Delegates of the American Medical Association.

An Ohio physician, Dr. Franklin L. Shively, Jr., Dayton, 1953 vice-president of the Montgomery County Medical Society and active in the development of the society's public relations program, presided over morning sessions of the conference.

Following remarks by Dr. George F. Lull, A. M. A. Secretary and General Manager, and by Dr. Walter B. Martin, president-elect, four physicians presented a symposium on how their societies make public relations programs work. After their discussions, a panel composed of Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association; Mr. William Alan Richardson, editor of *Medical Economics*; and Mr. Leo E. Brown, director of Public Relations, American Medical Association, directed questions to the speakers.

The luncheon speaker was Dr. Leo H. Bartemeier, Detroit psychiatrist, who discussed "What Motivates the Public's Feelings Toward Medicine."

Speakers on the afternoon program dealing with "Selling Our Economic System," were Mr. Howard W. Bennett, New York, Manager of Economic Education, Plant Community Relations Division, General Electric Company; and Mr. Roger Fleming, Washington, D. C., Secretary-Treasurer, American Farm Bureau Federation.

Subjects discussed under the general heading of "Mending Our PR Fences" were accreditation of hospitals; audit programs; mediation committees; and tissue committees.

The program closed with a prediction by Mr. Brown of "What's in Store in '54." Attending the meeting from Ohio in addition to Dr. Shively and Mr. Nelson were: Dr. Paul A. Davis, Akron, president of the Ohio State Medical Association; Dr. Richard C. Miller, Dayton, president of the Montgomery County Medical Society; Ohio members of the House of Delegates of the A. M. A.; Messrs. Stanley and Robert Mauck, Columbus Academy of Medicine; Mr. M. Paul Hanni, Executive Secretary, Cleveland Academy of Medicine, Cleveland; Mr. Robert F. Freeman, Executive Secretary, Montgomery County Medical Society; Mr. George H. Saville, Director of Public Relations, Ohio State Medical Association; and Mr. Hart F. Page, Assistant Director.

Facts and Policies About Annual Dues . . .

Amount of Dues; Date Due; Payable to Whom?; Those Exempt From Payment; Data on A. M. A. Dues and Exemptions; Getting Journals

HERE are some important facts and reminders regarding 1954 membership dues. It is vital for each physician to keep his membership in the State Association, his County Medical Society, and the A. M. A. up to date. Those who have not paid 1954 dues should get in touch with their County Society secretary-treasurer immediately.

Amount of Dues: State Association, $20.00; A. M. A., $25.00; County Society, amount varies from county to county—See your local secretary-treasurer.

Date Dues are Due: On or before January 1, 1954. Membership is on a calendar year basis.

Dues Payable to Whom?: Secretary-treasurer of County Medical Society. When paying dues to him, send check for total amount of local, State and A. M. A. dues. Maintaining membership in the A. M. A. is optional, but the large majority of Ohio physicians belong to the A. M. A. Don't send dues direct to Columbus Office—pay them to local Secretary-Treasurer.

Journals: State Association members receive *The Ohio State Medical Journal* as a part of their membership privileges—no extra charge for *O. S. M. A. Journal.* Those who pay dues to A. M. A. receive the *Journal of the A. M. A.* as a part of their membership privileges—no extra charge for *A. M. A. Journal.*

A dues-paying A. M. A. member may secure in lieu of the *A. M. A. Journal,* any other official publication of the A. M. A. **on special request by him direct to the A. M. A.** at 535 N. Dearborn Street, Chicago. These publications are: Archives of Internal Medicine, American Journal of Diseases of Children, Archives of Dermatology and Syphilology, Archives of Neurology and Psychiatry, Archives of Pathology, Archives of Surgery, Archives of Otolaryngology, Archives of Ophthalmology, and Archives of Industrial Hygiene and Occupational Medicine.

Those exempted from payment of A. M. A. dues must place a special subscription for the *A. M. A. Journal* direct to the A. M. A. or any one of the other publications if they desire to receive such publication.

Who is Exempt From State Dues: There are only two classes of members of the O. S. M. A. who are exempt from the payment of state dues, namely:

(a) **Military Members:** Members of the O.S.M.A. in military service as a result of the national emergency and who are not making military medicine a career, are entitled **to exemption from O. S. M. A. membership dues** while they are in the service. Dues paid by a member before entering the service will not be refunded, but dues will be waived if he enters the service prior to paying dues. Certification from local secretaries will be necessary in all such cases.

(b) **Aged or Disabled Members:** A member who **retires,** or has been retired, from active practice because of **age or disability** and who was in good standing at the time of retirement is exempt from the payment of State dues, **providing he requests such exemption and such request is approved in writing by the secretary-treasurer of his county medical society.**

Remember: The determining factor is not how old the physician is but whether he has retired from active practice.

Who Is Exempt From A. M. A. Dues?: The following physicians, who are members of the O. S. M. A. either through payment of O. S. M. A. dues or by exemption of O. S. M. A. dues, can carry membership in the A. M. A. without paying A. M. A. dues:

(a) **Military Members:** O. S. M. A. members in temporary military service prior to January 1, 1954, are entitled to A. M. A. membership **without payment of dues.** Members entering military service prior to July 1, 1954, will owe A. M. A. membership dues of $12.50—one-half year; those entering military service after July 1, 1954, will owe dues for the entire year—$25.00. Military members for whom A. M. A. dues are waived and who desire to receive *The A. M. A. Journal* while in the service may do so by buying, directly from the A. M. A., an annual subscription in the amount of $15.00. The *O. S. M. A. Journal* is sent to such members without charge.

(b) **Aged and Disabled Members:** O. S. M. A. members who are exempt from payment of O. S. M. A. dues because of retirement from active practice due to **age or disability** are entitled to A. M. A. membership without payment of A. M. A. dues. The names of such members will be certified automatically to the A. M. A. annually by

the Columbus Office after their names are entered on the O. S. M. A. roster as dues-exempt members for the current year.

(c) **Members 70 Years of Age:** Members of the O. S. M. A., after attaining the age of 70 years, will be eligible for membership in the A. M. A. without paying A. M. A. dues, **starting on January 1 following such member's 70th birthday, providing such member requests such exemption.** Such members should file their request for A. M. A. exemption with the Columbus Office after they have received their O. S. M. A. membership card for 1954, or any subsequent current year. The Columbus Office will certify their names to the A. M. A. This A. M. A. exemption will be automatic year by year, providing the physician's name is carried on the membership roster of the O. S. M. A., either as a dues-paying member or as a retired member.

Those Not Exempt From O. S. M. A. dues: The following are **not** exempt from the payment of O. S. M. A. dues:

(a) **Physicians in training (postgraduates, interns and residents) are NOT exempt from O. S. M. A. dues** and, therefore are **NOT** exempt from A. M. A. dues, as A. M. A. will not exempt such physicians from membership dues unless the state society does so.

(b) **Regular commissioned medical officers of the Army, Navy, Air Force, or U. S. Public Health Service, and permanent medical officers of the Veterans Service and the Indian Service are NOT exempt from O. S. M. A. dues.** If they desire to be members of the O. S. M. A., they must qualify the same as civilian physicians and pay current dues. However, physicians of these classes are eligible to apply for **Service Membership in the** A. M. A., and if accepted into Service Membership, will not be required to pay A. M. A. dues.

Send Change of Address Promptly: Occasionally a new member wonders why he does not receive the O. S. M. A. and A. M. A. journals at once. The answer is simple. It takes the O. S. M. A. Columbus Office about four weeks to get a new stencil made and the mailing list adjusted to take care of mailings to new members. It takes the A. M. A. longer because of its very large mailing list. Also, some months extra copies of the journals are quickly exhausted. Moreover, the Post Office Department frequently causes the delay in delivery. The Columbus Office makes a real effort to send out O. S. M. A. journals to new members by special handling but that can't always be expedited. If a new member fails to get the mazagine on two consecutive months, something is wrong and he should notify the Columbus Office. All members can help the Columbus Office in keeping the mailing list up to date by sending in changes of address promptly.

What To Write for

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

Telephone Courtesy Makes Friends. Here's one for your receptionist. Available free from your local telephone office or from Miss Helen L. Kiess, Ohio Bell Telephone Company, 35 E. Gay Street, Columbus 15.

Publications About Your Health—1953. Contains list of printed publications for health education of the public, as issued by the Bureau of Health Education, American Medical Association. Free from the Bureau, American Medical Association, 535 North Dearborn Street, Chicago 10.

Preparing for School Emergencies of Sickness or Accident. (School Health Guide No. 2) Valuable information for supplying guidance to schools working on a medical emergency program. Published by, and available without charge from Committee on School Health, Ohio State Medical Association, 79 E. State St., Columbus 15.

List of Medical Motion Pictures Available from the A. M. A. Lists 77 medical motion pictures suitable for medical societies, medical schools, and hospital staff meetings. Some for physicians called upon to address lay groups. Available free from Committee on Medical Motion Pictures, A. M. A., 535 N. Dearborn St., Chicago 10.

The United States Constitution, Text With Analytical Index, Unratified Amendments. A 62-page document published in 1953, available from Government Printing Office, Washington 25, D. C., at 20 cents. (Catalog No. 83-1:H. Doc. 211)

Home Accident Prevention, Guide for Health Workers. A booklet for professional public health people who are engaged in or contemplating a program to reduce home accidents. Published in 1953, 75-pages. Available for 30 cents from Government Printing Office, Washington 25, D. C. (Catalog No. FS 2.2:Ac 2)

Home Shelters for Family Protection in an Atomic Attack (Civil Defense Technical Manual 5-5) Includes step-by-step building instructions, drawings and illustrations. Price 30 cents from Government Printing Office, Washington 25, D. C. (Catalog No. FCD 1.6/3:5-5)

What to Do in Case of an Automobile Accident. Things you need to know if you are involved in an automobile accident, with emphasis on information to be filed under the new responsibility law. Issued as a public service by Ohio State Bar Association, State House Annex, Columbus 15.

Certain V. A. Fees Increased . . .

Raises Granted In Some Items of Fee Schedule As Result of Requests Made by State Medical Association; Data on Home Town Program

FEES for some of the services rendered by Ohio physicians to veterans eligible for care under the Home Town Medical Care Program for Veterans have been increased and will become effective just as soon as an amendment can be made to the working agreement between the Veterans Administration and the Ohio State Medical Association.

Changes in items of the fee schedule were proposed a year ago by the Ohio State Medical Association, based on a report of the Committee on Medical Care of Veterans. After considerable study of the proposals, the Veterans Administration submitted counter proposals. Some of these were identical with suggestions made by the State Association. In other instances, smaller increases were granted or the fee left unchanged.

APPROVED BY THE COUNCIL

Meeting on December 12, The Council of the State Association reviewed the V. A. proposals. Inasmuch as an increase had been allowed in most of the items for which changes had been requested by the State Association, The Council approved the V. A. proposals and authorized President Davis and the Executive Secretary to negotiate a proper amendment to the agreement between the V. A. and the State Association.

Following is a summary of the fees which will be paid by the V. A. under the amended agreement:

EXAMINATION FEES

0011—Examination to determine need of hospitalization, $3.00. (No change.) The O. S. M. A. had requested a $5.00 fee for examination in office and $7.50 for examination in the home.

0012—Complete general routine physical examination, including routine urinalysis, hemoglobin estimation Tallqvist and withdrawal of blood for Wassermann or Kahn, $9.00. (Increase from $7.50.) The O. S. M. A. had requested $10.00 for complete physical examination in office and $15.00 for bedside examination.

HOME EXAMINATIONS

The following note was inserted, applying to Items 0011 and 0012: "When an examination is done in the home, the fee for the home call ($5.00) will be added to that of the examination." This means that $8.00 will be paid for a home examination as specified in 0011 and $14.00 will be paid for a home examination as specified in 0012.

TREATMENT VISITS

Fees for regular visits within city limits were allowed as follows, with "Day" visits being regarded as those made from 8:00 A. M. to 7:00 P. M. and "Night" visits from 7:00 P. M. to 8:00 A. M.:

0013—Office (day), First, $4.00. (Increase from $3.50.) O. S. M. A. had requested $5.00.

0014—Office (day), Subsequent, $3.00. (Increase from $2.50.) O. S. M. A. had requested $3.00.

0015—Home (day), First, $5.00. (Increase from $4.00.) O. S. M. A. had requested $7.00.

0016—Home (day), Subsequent, $4.00. (No increase.) O. S. M. A. had requested no increase.

0017—Hospital (day), First, $4.50. (Increase from $4.00.) O. S. M. A. had requested $7.00.

0018—Hospital (day), Subsequent, $4.50. (Increase from $3.50.) O. S. M. A. had requested $4.00.

0019—Home (night), First, $8.00. (Increase from $7.00.) O. S. M. A. had requested $9.00.

0020—Home (night), Subsequent, $7.00. (No increase.) O. S. M. A. had requested no increase.

0021—Hospital (night), First, $8.00. (Increase from $7.00.) O. S. M. A. had requested $9.00.

0022—Hospital (night), Subsequent, $7.00. (No increase.) O. S. M. A. had requested no increase.

OTHER ITEMS

The O. S. M. A. had requested a fee of $15.00 for biopsy, with report of histological examination, an increase of $5.00. This was not agreed to by the V. A. However, the wording of the item—0304—was changed to read, "Biopsy with report (4 copies histological technique performed by hospital staff) . . . $10.00."

Item 0305 was revised to read as follows: "Histological technique performed outside V. A. hospital and slides and blocks furnished $15.00." Previously it had read: "Biopsy (without report of tissue examination) . . . $5.00."

Item 9110—Laminagraphy—carries a new fee of $20.00, as requested by the O. S. M. A. It had been $15.00.

DATA ON OHIO PROGRAM

At the request of The Council of the Ohio State Medical Association, medical directors of the two regional Veterans Administration Offices in Ohio

—Cleveland and Cincinnati—made a review of their files for the fiscal year ending June 30, 1953, and supplied certain interesting data regarding the operations of the Home Town Care Program in this state.

These reports reveal that from July 1, 1952, to June 30, 1953, a total of approximately 10,013 veterans received medical care from fee-basis physicians under the Home Town Care Program. Of these, 5,076 were from 38 counties in the Cleveland Region and 4,937 from 50 counties in the Cincinnati Region.

A total of approximately 1,865 fee-basis physicians took part actively in the program during the fiscal year—1,008 in the Cleveland Region and 857 in the Cincinnati Region. Physicians in the Cleveland Region who participated were paid a total of $172,486; those in the Cincinnati Region, $276,402—a total of approximately $448,888 for the state as a whole.

During the year, 23,870 veterans received treatments at the three out-patient clinics operated by the Veterans Administration in the Cleveland Region and 7,329 received treatments from the two clinics operated in the Cincinnati Region—a total of approximately, 31,199.

New Members of O.S.M.A.

The following are the names of new members of the Ohio State Medical Association since November 9, 1953. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CLINTON COUNTY
Brown, Henry M., Wilmington

CUYAHOGA COUNTY
Chagerben, Badih, Cleveland
Deme, Charles, Cleveland
Epple, Siegfried M., Cleveland
Furr, Walter E., Jr., Cleveland
Kesiunaite, Dominika, Cleveland
Lazdins, Adolfs K., Cleveland
Lelbach, Anthony J., Cleveland
Smanik, Edward J., Berea
Smith, Edwin L., Cleveland
Weidle, Mary A., Cleveland
Wertman, Daniel E., Cleveland

FRANKLIN COUNTY
Schmelzer, William C., Columbus

FULTON COUNTY
Cotterman, Vernon L., Wauseon

HAMILTON COUNTY
Berning, Donald N., Cincinnati
Gleaves, Clifford Kent, Cincinnati
Hamblet, John B., Cincinnati
Schmerge, John C., Cincinnati
Simon, David L., Cincinnati
Tenczar, Francis J., Cincinnati

KNOX COUNTY
Royer, Ralph W., Mt. Vernon
Trott, Clinton, Mt. Vernon

LUCAS COUNTY
Binkley, Robert F., Toledo

MONTGOMERY COUNTY
Cassel, William G., Military Service

SCIOTO COUNTY
Horn, Walter E., Portsmouth
Rardin, Robert B., Portsmouth

SUMMIT COUNTY
Angell, Jeanne A., Massillon
Baird, William C., Akron
Hart, Richard H., Akron
Neitz, Richard R., Tallmadge
Rankin, Fred M., Jr., Akron
Woodbury, Jefferson C., Akron

WAYNE COUNTY
Baer, Robert D., Dalton

Do You Know? . . .

Dr. John J. Phair, professor of preventive medicine of the University of Cincinnati College of Medicine, has been elected a member of the American Board of Preventive Medicine and Public Health. He also was elected secretary of the Section on Epidemiology of the American Public Health Association and the Conference of Professors of Preventive Medicine.

* * *

Dr. Edward J. McCormick, Toledo, President of the American Medical Association, was principal speaker at the fourth annual "Campus Conference on Religion" in the University of Toledo.

* * *

Plans are being made to hold the Sixth District Postgraduate Day on Wednesday, October 27, 1954, in Akron.

* * *

Dr. Carl J. Wiggers, Cleveland, has been named recipient of the 1954 Award for Distinguished Achievement given by *Modern Medicine*. He recently retired after many years as professor of physiology at Western Reserve and is now with the Bunts Educational Institute.

* * *

On invitation of the Department of Ophthalmology, University of Iowa, Dr. K. W. Ascher, Cincinnati, gave a two-day seminar on aqueous veins and their bearing on glaucoma at the Eye Clinic of University Hospitals, Iowa City.

* * *

Dr. James B. Johnson, Jr., Newark, was elected a member of the executive board of the National Society for Crippled Children and Adults at the recent annual meeting in Chicago.

* * *

Mr. George H. Saville, Director of Public Relations of the Ohio State Medical Association, is the new President of the Public Relations Society of Columbus.

* * *

Dr. Harry Goldblatt, who in 1946 left Cleveland to develop and direct the Institute for Medical Research at the Cedars of Lebanon Hospital, Los Angeles, has returned as director of laboratories at Mount Sinai Hospital.

* * *

The Mid-Ohio Valley Association met at the Betsey Mills Club in Marietta on December 10. The subject, "Peptic Ulcer—Its Medical and Surgical Management," was discussed by Dr. Edwin H. Ellison, associate professor of surgery, and Dr. William Bradley, assistant professor of medicine, Ohio State University College of Medicine.

* * *

Dr. Jonathan Forman, Columbus, Editor of *The Journal*, addressed a meeting of the Knox County Conservation District on the subject, "Food and Health."

The Problem of Nausea and Vomiting:

ITS TREATMENT WITH DRAMAMINE®

Whenever nausea, vomiting and vertigo are disturbing and complicating factors, Dramamine may be used with confidence.

Keats[1] outlines the wide list of conditions in which Dramamine (brand of dimenhydrinate) has proved valuable as follows: "It has been well established in the control of motion sickness. It has been used effectively in the prevention and treatment of seasickness, airsickness, [in the treatment of] the nausea of pregnancy, Ménière's syndrome, . . . radiation sickness . . . and postfenestration reactions. . . . The site of action is imperfectly understood, but there is indication of an action of depressing labyrinthine function or its neural pathways, a highly selective central action, or both. Few side reactions of this drug have been noted."

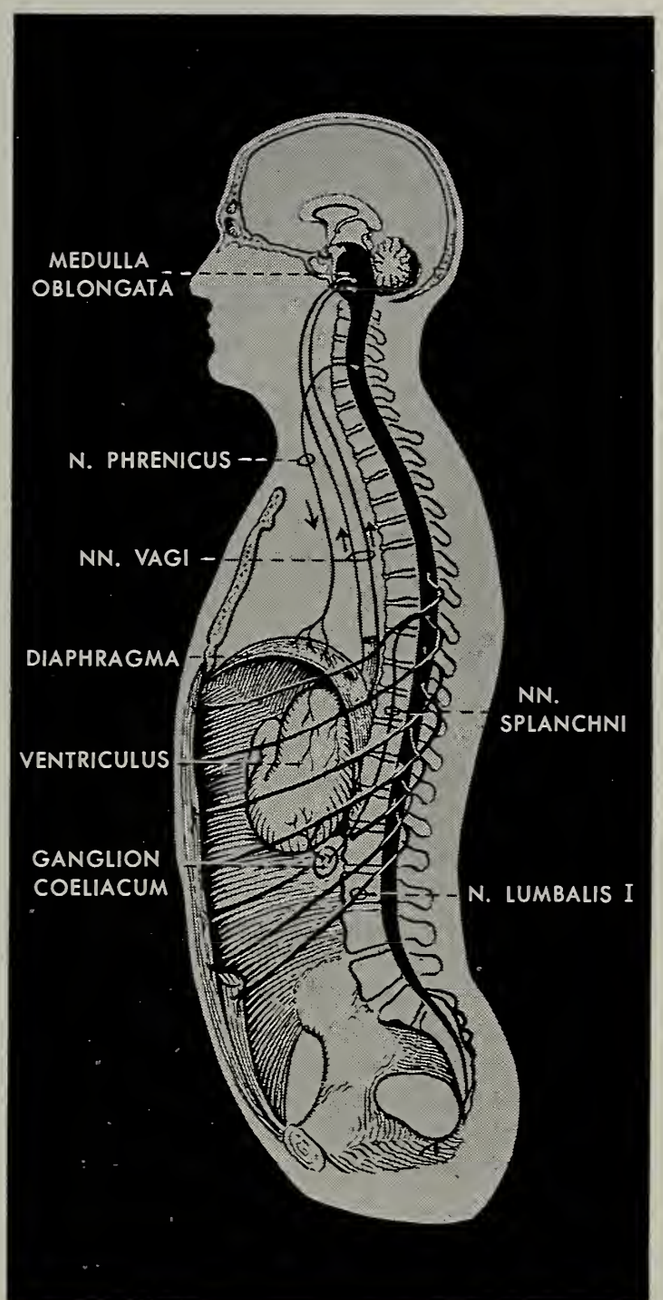
The usual dose for motion sickness is 50 mg. (one tablet) taken one-half hour before departure and, if necessary, before meals for the duration of the journey. Control of nausea and vomiting of other conditions and severe motion sickness is achieved, with minimal drowsiness, by a dosage of 100 mg. every four hours.

"[Dramamine] is administered orally or rectally. . . . The same doses may be administered rectally by insertion of the tablet or other suitable form. . . ."[2]

Dramamine Liquid is particularly useful for children.

Dramamine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Keats, S.: Ataxic Cerebral Palsy with Akinetic Seizures: Dramatic Response to Dramamine, J. M. Soc. New Jersey *50*:53 (Feb.) 1953.
2. Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1953. Philadelphia, J. B. Lippincott Company, 1953, p. 471.



THE VOMITING REFLEX: *Vagus→ nodose ganglion→ solitary tract→ spinal cord→ cervical, thoracic and lumbar nerves to diaphragm, cardiac sphincter, stomach, abdominal and pelvic musculature. (After Krieg, W. J. S.: Functional Neuroanatomy, ed. 2, New York, The Blakiston Company, Inc., 1953, p. 104.)*

SEARLE *Research in the Service of Medicine*

Next Session of Congress . . .

Plenty of Fireworks on Medical-Health Proposals Expected In 1954 When Lawmakers Convene; Summary of Some of the Important Issues

FIREWORKS on the medical-health front may be anticipated during the second session of the 83rd United States Congress which convenes January 6.

As the session ages, representatives of the medical profession will have to keep in close touch with their congressmen and give them information and suggestions on pending bills.

HOTTEST QUESTIONS

Here are some of the questions on the fire:

Possible changes in the laws relating to the Veterans Administration, especially provisions dealing with medical and hospital benefits for veterans with disabilities which are not the result of military service.

Proposal to consolidate all medical and health activities in a new agency—United Medical Service.

Bills which might be drafted following hearings by the House Commerce Committee on the "nation's health."

DEPENDENT CARE

Measures dealing with medical care for dependents of servicemen, especially those which would provide for such care from private physicians and hospitals—not by physicians in uniform or in military hospitals where private services and facilities are readily available.

Hearings, and possible action on recommendations, by the Hoover Commission on Reorganization of the Executive Branches of the U. S. Government and by the Manion Commission on Federal-state relationships.

BRICKER AMENDMENT

The proposed Bricker amendment to the Constitution to prevent changes in basic laws by international treaties or without specific action by Congress on proposed legislation.

The Reed-Jenkins proposals, making it possible for self-employed persons, such as physicians, to deduct from income tax returns a portion of premiums paid by them for voluntary retirement insurance.

Broadening of the Social Security program to cover groups not covered at present, including physicians, dentists, and others who are self-employed.

Amendment to the Social Security Act which would preserve the pension rights of disabled persons who cannot continue employment or have to work at reduced income.

SOCIAL SECURITY PROPOSALS

Following are some boiled-down items pertaining to legislative planning in Washington and pre-session activities:

Congress is likely to make some changes in the social security law, particularly for the six out of ten aged persons in the population not now covered by Old Age and Survivors Insurance. This is indicated by Rep. Carl T. Curtis (R., Neb.), chairman of the House Ways and Means subcommittee which has been conducting extensive hearings on social security. Mr. Curtis made the prediction as the hearings concluded November 27.

Chairman Daniel A. Reed (R., N. Y.) of the House Ways and Means Committee has indicated that in his opinion Congress should not force mandatory social security coverage on physicians and others who don't want it. Mr. Reed's committee will hold public hearings after the first of the year. The administration bill, introduced last August, would mandatorily take in physicians, dentists, farmers and virtually all other groups of self-employed.

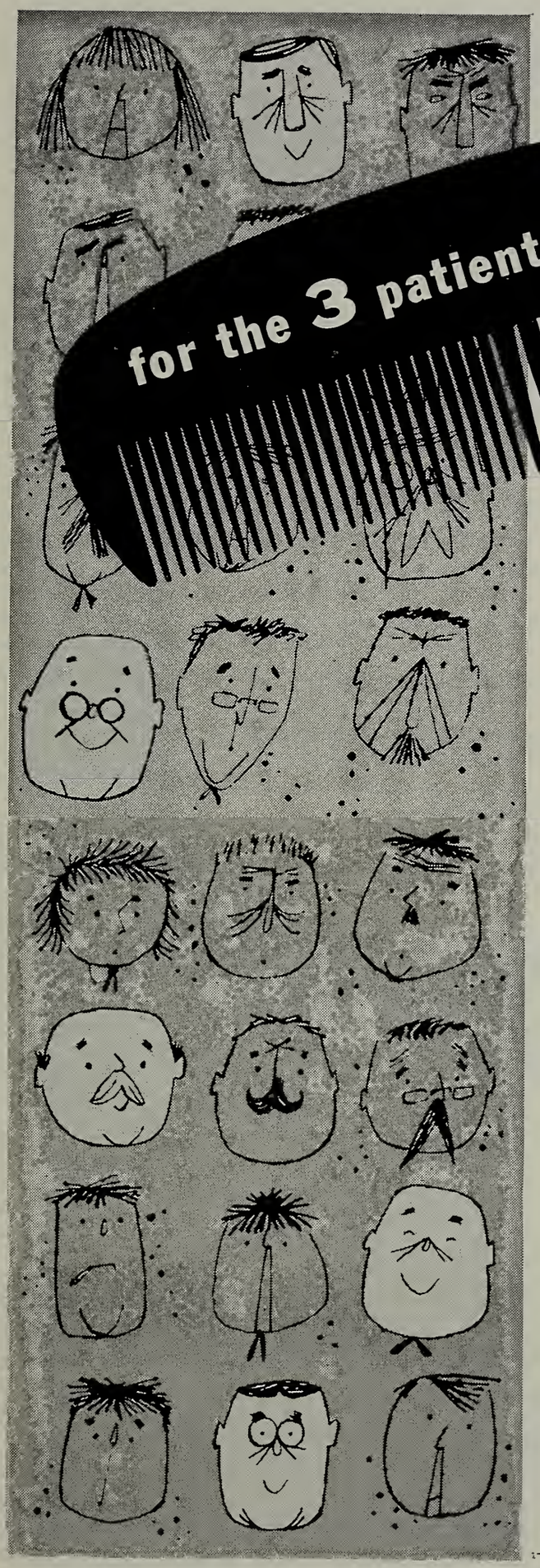
Mr. Reed declared: "I believe that social security coverage should be extended to any group **which desires it.**" At its meeting in St. Louis, the A. M. A.'s House of Delegates reaffirmed that the country's physicians **do not desire** social security.

Other committee objectives, as stated by Mr. Reed: Liberalize the present $75 per month limit on earnings of OASI recipients, raise the level of minimum benefits and allow the social security tax to go up one-half per cent as scheduled on January 1.

MARGIN OF VOTES IS CLOSE

Leaders of both parties are keeping close tab on the thin margin of control held by the Republicans. In the Senate the line-up is 48 Democrats, 47 Republicans and 1 Independent (in the event of a tie, the Vice-President could cast the deciding vote). In the House the division is 219 Republicans, 215 Democrats and 1 Independent, with 218 seats required for a bare majority.

A survey of the past four Congresses shows an average of 19 House vacancies due to deaths or resignations in each Congress; the total so far in the 83rd is 7. The survey further discloses there are 34 Republicans and 25 Democrats in



who have seborrheic dermatitis of the scalp

FOR the scalp-scratchers, shoulder-brushers and comb-clutterers, there's welcome relief with SELSUN Sulfide Suspension.

Published reports on more than 400 cases[1 3] show that SELSUN completely controls seborrheic dermatitis in 81 to 87 percent of all cases, and in 92 to 95 percent of common dandruff cases. It keeps the scalp free of scales for *one to four weeks*—relieves itching and burning after only two or three applications.

SELSUN is remarkably simple to use. Your patients apply it and rinse it out while washing the hair. It takes little time. No complicated procedures or messy ointments. Ethically advertised and dispensed only on prescription. In 4-fluidounce bottles with complete directions on the label.

Abbott

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SULFIDE *Suspension*

(SELENIUM SULFIDE, ABBOTT)

1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

1-348-54

the House who will be 65 years of age or older by the end of 1953.

The survey notes that, should Democrats win two Republican seats during the session, there would be an exact division in membership in the House. And should the Independent not vote, there would be a deadlock in organizing the House, a situation that has occurred only twice in the past 100 years.

MILITARY BENEFITS

A 5-man committee of admirals and generals named by the Secretary of Defense believes that a serious deterioration of career service can be halted only by such things as higher military pay and more medical and dental care for dependents. The report was made public a day after Assistant Secretary of Defense John Hannah warned that the services were losing career men in numbers "so great as to be disturbing." He, too, cited low military pay and a "continual nibbling away at fringe benefits."

The report said benefits must be fully restored, must be declared by law to be a part of service pay, and in some cases must be increased. It defined benefits as hazardous and incentive duty pay, sea and foreign duty pay, medical and dental care for dependents, better and cheaper housing, and better provision for education of service children.

In making the report public, Mr. Hannah said it would receive careful consideration from the military services, the Defense Department and the Joint Chiefs of Staff. He added that its release did not imply "approval or acceptance" by the department "in every respect."

The A. M. A. believes dependents should receive medical care from private physicians and in private hospitals if such services and facilities are available.

Stevenson Memorial Fellowship Planned in Cincinnati

A memorial fellowship in honor of the late Dr. Frank E. Stevenson in the field of infectious diseases is being instituted by the Cincinnati Pediatric Society and the Pediatric Department of the University of Cincinnati College of Medicine.

A special committee of the Cincinnati Pediatric Society and of the Pediatric Department of the University is receiving contributions to further the fellowship fund. Such contributions may be made through the office of the College of Medicine.

Recipient of the scholarship may undertake study at any medical center in the country for a period up to one year, but will be asked to return to the University of Cincinnati later to pursue his studies and to provide instruction.

Dr. Stevenson was associated with the Pediatric Department at the University for 30 years before his death last July.

U. M. W. Fund Lists Services For Which Benefits Cannot Be Paid

A letter has been sent by Dr. Leslie A. Falk, medical director of the area office of the United Mine Workers Welfare and Retirement Fund to the medical staffs of hospitals in the area, which includes Ohio, asking their cooperation in billing the fund only for services which are within the scope of the program.

Dr. Falk's letter addressed to medical staffs and headed "Medically Unnecessary Procedures," reads as follows:

"It has been suggested that the Fund point out to hospital medical staffs the fact that only **medically necessary** surgery, and other medically necessary procedures, are within the scope of the Fund program. Examples of the types of procedures for which the Fund cannot pay are as follows:

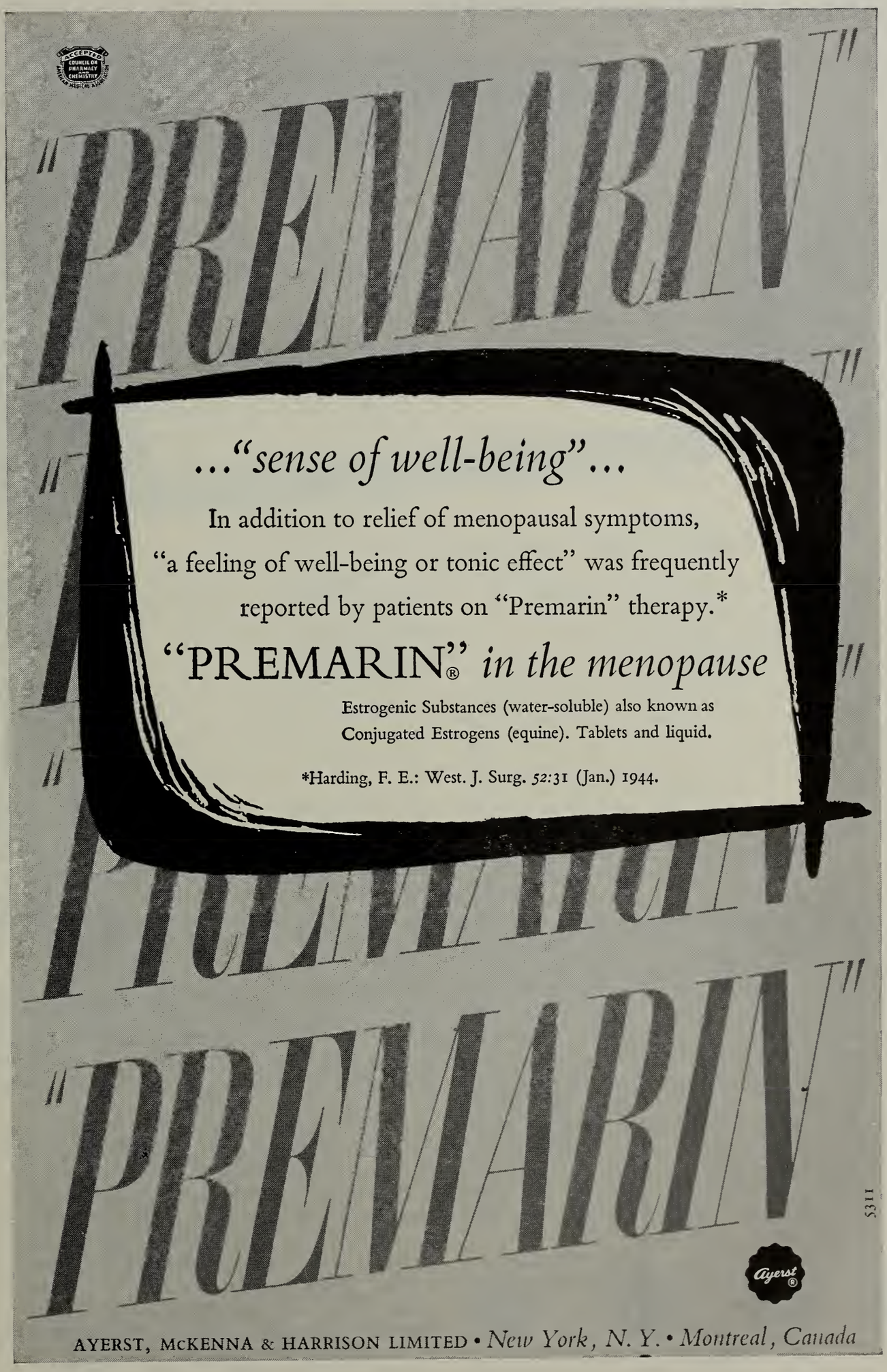
"1. Payment of the expenses involved in the performance of purely cosmetic surgery for no medical purpose other than the patient's whim or desire is not within the scope of the Fund program. Payment for nose straightening operations will be considered by prior authorization if a significant improvement in the airway is thereby accomplished. Financial responsibility for nose straightening operations performed for psychological reasons will be accepted by the Fund on the advice of a psychiatrist or a suitably trained specialist to certify them as medical prescriptions.

"2. Payment for sterilization operations performed at the request of the husband or wife in the male or female, without the existence of medical indications for sterilization operations, is not within the scope of the Fund program. Multiparity *per se*, without the existence of associated medical reasons, cannot be considered justification for Fund payment for sterilization procedures. Whether the physician provides the service or not is a matter between him and the patient, in accordance with State law and hospital medical staff rules, but Fund payment must be restricted to **medically** necessary procedures.

"3. Operations or any other procedures provided solely at the patient's request, and against the better judgment of the attending physician, cannot be provided at the expense of the Fund.

"Should there be any questions about these matters, it will be appreciated if we would be contacted, and clarification will be made willingly and freely. Any further suggestions for developing a sound and cooperative policy along this line will be very much appreciated."

The Southwestern Ohio Society of General Physicians gave a program on the subject, "Present Concepts and Treatment of Eye Diseases and Injuries," on November 29 at the Hotel Alms, Cincinnati.


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"PREMARIN"
...*"sense of well-being"*...
In addition to relief of menopausal symptoms,
"a feeling of well-being or tonic effect" was frequently
reported by patients on "Premarin" therapy.*
"PREMARIN"® *in the menopause*
Estrogenic Substances (water-soluble) also known as
Conjugated Estrogens (equine). Tablets and liquid.
*Harding, F. E.: West. J. Surg. 52:31 (Jan.) 1944.
5311
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You and Your Public . . .

A Few Gleanings on Things Other County Medical Societies and Other Doctors Are Doing To Improve Understanding on the Part of Patients

THE Kings County, N. Y., Medical Society has turned up some enlightening information in regard to patients' complaints about doctors. After an analysis of the 40 cases handled by the society's mediation committee during 1952-1953, the society released the following breakdown of complaints:

Improper diagnosis or treatment—14.
Failure to explain costs—6.
Failure to make call where patient knew doctor—6.
Overcharging—4.
Failure to give reports to patients on their conditions—3.
Failure to treat patients in an emergency —2.
Refusal to treat patient—2.
Not doctor patient thought would treat him—2.
Criticism of other doctor to patient—1.
Failure to follow up patient's case—1.
Type of bill submitted—1.
Improper examination—1.

According to *The PR Doctor*, of the A. M. A., in which this item appeared, "These figures reveal one important point—that though some complaints are based on actual medical service rendered by the physician, the majority of kicks could be eliminated if each physician practiced sound public relations as well as medicine."

* * *

A cooperative venture of physicians and pharmacists in Evansville, Indiana, is an interesting public relations project. In many communities, pharmacists provide physicians with imprinted prescription blanks. In Evansville, physicians and druggists worked out a plan whereby the pharmacists will provide prescription blanks without the name of the drug store.

At the bottom of the new prescription blank is the notation, "Member, Vanderburgh County Medical Society." On the back this message appears: "The Vanderburgh County Medical Society and The Southwestern Indiana Pharmaceutical Association are united to safeguard the health of our community. Take this prescription blank to the pharmacist of your choice."

Orders for the blanks are handled through the medical society office and several types are offered. The physician prepares his own copy, giving his name, address, telephone number, registry number, etc., and indicates whether he wants number of refills listed on the blank. The pharmaceutical association urges the physicians to use a standard size, 4¼x5½ inch blank to facilitate filing by pharmacies.

* * *

How many times have you been at a baseball game or a movie when a physician was called away for an emergency? To allow discreet paging of doctors at large gatherings and eliminate unnecessary embarrassment on the doctor's part, the Medical Society of Milwaukee County, Wisconsin, has initiated a new system.

Each member has been assigned a numbered card which is to be used by members of his family, his hospital, the Medical Society Physicians' Service, or his office, when it is necessary to page him while he is in a public place or at a public gathering.

* * *

In an editorial in the *Columbus Academy of Medicine Bulletin* recently the plea was made that doctors who appear in radio and television programs "talk to laymen in a warm and understandable language."

Commenting upon certain television shows, the writer said: "Just get any one of us (doctors) in front of the public, especially on television and what happens? Our backs get stiff as pokers, our faces assume the expression of one with advanced paralysis agitans and we unintelligibly spout multisyllabic gibberish. How can we prove to the public that we are human when on TV we make like men from Mars with horn-rimmed specs and talk like Einstein?" The editorial suggested that "all physicians be as simple, warm, and friendly as Arthur Godfrey."

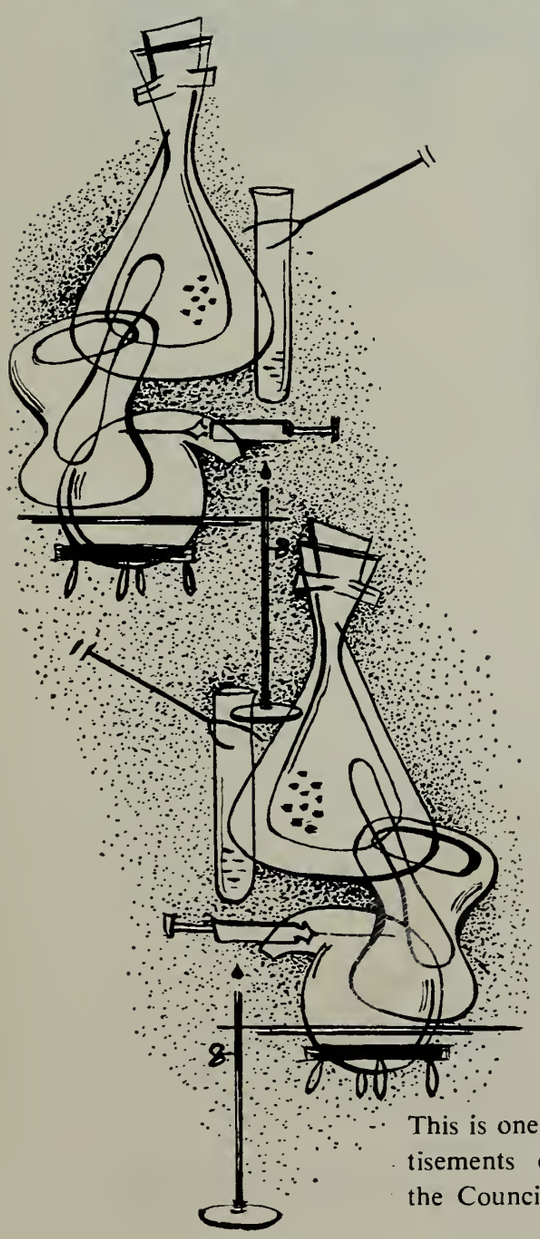
* * *

To many in the medical field, the letters "PR" mean just one thing—"Public Relations." New Jersey physicians in outlining their public relations goals have come up with an interesting concept of the meaning of those two vital letters "PR."

It is contained in their public relations slogan of 1953: "Public Relations for Medicine Means Personal Responsibility for You."

Commenting on "Personal Responsibility," the New Jersey Medical Society Membership News Letter said: "Successful public relations can be achieved only if all who represent an agency or a cause before the general public consistently and dependably do all those things which tend to encourage, and avoid all those things which tend to discourage, the affection and esteem of the general public. There is no other way."

What is the status of____?



Many times you have asked yourself, "Is the indicated drug Penicillin . . . Chloramphenicol . . . Aureomycin . . . Sulfadiazine . . . a combination . . . or what?" This same problem may confront you many times . . . not only with the antibiotics—but actually in any specific field where there are numerous drugs . . . and you are faced with the problem of determining which might be the therapy of choice for a given condition.

The need for such clarification has always been apparent to the Council on Pharmacy and Chemistry of the American Medical Association. Its frequent publication of special status reports in THE JOURNAL is designed to help answer such questions for you.

Information about new drugs—clinically proved indications . . . experimental uses . . . correct dosages . . . contra-indications . . . and similar facts—is frequently presented by the Council. Its announcements of newly accepted products also help keep you up-to-date on new and useful drugs. These notices which appear in THE JOURNAL almost every week can be a definite guide to you in knowing what preparations are Council accepted . . . how they are best used . . . and how they can be most effective in your daily practice.

Insistence on Council accepted products is one reliable guide to clinically tested products.

This is one of a series of advertisements designed to explain the Councils' functions to you.

ACCEPTED — COUNCIL ON PHARMACY AND CHEMISTRY — AMERICAN MEDICAL ASSOCIATION

ACCEPTED — COUNCIL ON PHYSICAL MEDICINE AND REHABILITATION — AMERICAN MEDICAL ASSOCIATION

ACCEPTED — COUNCIL ON FOODS AND NUTRITION — AMERICAN MEDICAL ASSOCIATION

ACCEPTED — COMMITTEE ON COSMETICS — AMERICAN MEDICAL ASSOCIATION

A.M.A. House of Delegates . . .

Digest of Official Actions Taken at Recent St. Louis Session; Detailed Articles To Be Published Later; Ohio Represented by Seven Delegates

THE House of Delegates of the American Medical Association, meeting in St. Louis, December 1-3, took important policy actions on social security, voluntary health insurance, medical ethics and unethical practices, medical education, hospital accreditation, military affairs and a wide variety of subjects affecting both physicians and the public.

Ohio was officially represented in the House of Delegates by Drs. L. H. Schriver, Cincinnati; C. C. Sherburne, Columbus; A. A. Brindley, Toledo; William M. Skipp, Youngstown; George A. Woodhouse, Pleasant Hill; Herbert B. Wright, Cleveland; and Carll S. Mundy, Toledo. Dr. Mundy was seated on the official request of Dr. Paul A. Davis, Akron, president of the Ohio State Medical Association, in place of Dr. Carl A. Lincke, Carrollton, an official delegate who was unable to attend. Dr. Davis, also, served in the House of Delegates as delegate from the Section on General Practice.

Serving on important reference committees were the following Ohio delegates: Amendments to the Constitution and By-Laws, Dr. Skipp; Reports of Board of Trustees and Secretary, Dr. Schriver; Reports of Officers, Dr. Woodhouse.

Following is a digest of some of the actions taken by the official body of the A. M. A. Articles will appear in future issues of *The Journal*, presenting in detail actions by the House of Delegates on some of the more important questions discussed.

EMPHASIZE "VOLUNTARY" PENSION PROGRAMS

Approving a recommendation by its Reference Committee on Legislation and Public Relations, the House passed a resolution reaffirming its opposition to the compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act and advocating passage of the Jenkins-Keogh bills now pending in Congress. These bills were described as providing for "the development of a voluntary pension program which is equitable, free from compulsion, and satisfies the retirement needs of physicians."

The same committee report urged continued action to obtain passage of the Bricker Amendment (S. J. Res. 1) and approved the principle of legislation which would reduce or remove the limitation on the deduction of medical and dental expenses for income tax purposes.

It also opposed any further extension of the "Doctor Draft" Law beyond the present expiration date of June 30, 1955. The report said that "your Committee feels strongly that there should be no further extension of the 'Doctor Draft' Law. We feel that the legislation is discriminatory and urge the Committee on Legislation and the Board of Trustees to actively oppose any further extension."

The House acted to accelerate the development of voluntary health insurance by passing a resolution requesting the Council on Medical Service to proceed immediately with a special study of the problems of catastrophic coverage and coverage for retired persons. The Council was asked to present its findings and recommendations to the House not later than the 1954 Clinical Meeting.

SEEK TO DISTINGUISH "HOSPITAL SERVICE"

Another resolution on voluntary health insurance, adjudged to be emergency business by the Reference Committee on Insurance and Medical Service and then passed by the House, stated that "the American Medical Association condemns all insurance contracts which classify any medical service as a hospital service." The resolution reaffirmed previous actions of the House defining pathology, radiology, anesthesiology and physiatry as medical services.

A second emergency resolution, which would have endorsed the principle of federally subsidized scholarships for prospective military personnel in order to encourage the building up of a career-basis medical corps for the armed forces, was referred by the House to the Board of Trustees for study and action.

A resolution introduced by the Iowa State Medical Society, calling for approval of a joint-billing procedure involving services rendered by two or more physicians, was referred to the Judicial Council, at the suggestion of the Reference Committee on Miscellaneous Business, with the recommendation "that the Judicial Council investigate the factors involved in the matter as presented and determine if there are new factors or new facets that would cause it to change the opinion" determined in 1952.

The House approved a revision of one section of the Principles of Medical Ethics of the A. M. A. which clarifies the relationship of physicians to all forms of public information media. The revision had been worked out by the Council on Constitution and By-Laws.

The new phrasing of the Principles of Medical Ethics reads as follows: "An ethical physician

Pneumonia weather...
the season
for bacterial
respiratory tract
infections



a time
for...

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BRAND OF OXYTETRACYCLINE

The value of Terramycin in promptly controlling otitis media, severe sinusitis, laryngotracheobronchitis, bacterial pneumonia and virtually all infections of the respiratory tract, due to or complicated by the many organisms sensitive to Terramycin, is now a matter of clinical record.

Because of its excellent toleration and rapid response, Terramycin is a therapy of choice for bacterial respiratory tract infections. Among the convenient dosage forms of Terramycin are Capsules, Tablets (sugar coated), good-tasting Oral Suspension, non-alcoholic Pediatric Drops, Intravenous for hospital use in severe infections.

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may provide appropriate information regarding important medical and public health matters which have been discussed during open medical meetings or in technical papers which have been published, and he may reveal information regarding a patient's physical condition if the patient gives his permission, but he should seek the guidance of appropriate officials and a designated spokesman of component or constituent medical societies."

TO STUDY ETHICAL PROBLEMS

In an effort to solve the publicity problems resulting from unethical practices by a small minority of doctors, the House referred to the Board of Trustees a resolution calling for appointment of a special committee with broad professional representation to study all aspects of the problems. The Board was asked to study and implement the intent of the resolution and to report its findings to the House at the June, 1954, meeting in San Francisco.

To clarify misunderstandings among physicians regarding the rules and regulations of the Joint Commission on Accreditation of Hospitals, especially as they concern the role of the Department of General Practice in a hospital, the House adopted the following resolution:

"That this House of Delegates of the American Medical Association request the Joint Commission on Accreditation of Hospitals to publish an article, or series of articles, in *The Journal of the American Medical Association* and other official publications circulating among the medical and hospital professions, to acquaint the medical-hospital profession with the regulations, by-laws and their interpretations, and that the Commission clarify the methods by which an aggrieved hospital or its staff may appeal a decision with which they are not in agreement."

ANOTHER CONTRIBUTION TO A. M. E. F.

In the field of medical education the House was informed that a fourth grant of $500,000 had been made by the American Medical Association to the American Medical Education Foundation for financial aid to the nation's medical schools. The Foundation reported that its 1953 income now totals $1,174,000 and that the number of contributors now is more than double the total in 1952.

At the opening session of the House, Dr. McCormick, Toledo, in his presidential address made a strong appeal to the nation's physicians for "action that will further the full confidence of the public in our profession."

"Good public opinion cannot be bought," he declared. "It must be earned through exemplary conduct and genuine service in the public interest. Whatever money the A. M. A. and its constituent societies spend for public education and public relations is wasted unless individual physicians take wholehearted interest in assuring the success of these ventures."

Dr. Joseph I. Greenwell, New Haven, Kentucky, was acclaimed as the 1953 "General Practitioner of the Year." The annual medal and citation for community service by a family physician were presented to Dr. Greenwell by President McCormick.

Borowski Leaves Health Department To Administer Hospital

Anthony J. Borowski, Dr. P. H., chief of the Hospital Facilities Division of the Ohio Department of Health, has resigned from that post to accept a position as administrator of the Barberton Citizens Hospital.



A. J. BOROWSKI, DR. P. H.

Dr. Borowski has headed the Hospital Facilities Division since its organization late in 1947 to administer the hospital building program under the Hill-Burton Law. Under his supervision the Division furthered some 70 Ohio hospital building projects of all sizes. Hill-Burton Federal funds amounted to as much as one-third of the construction in many instances.

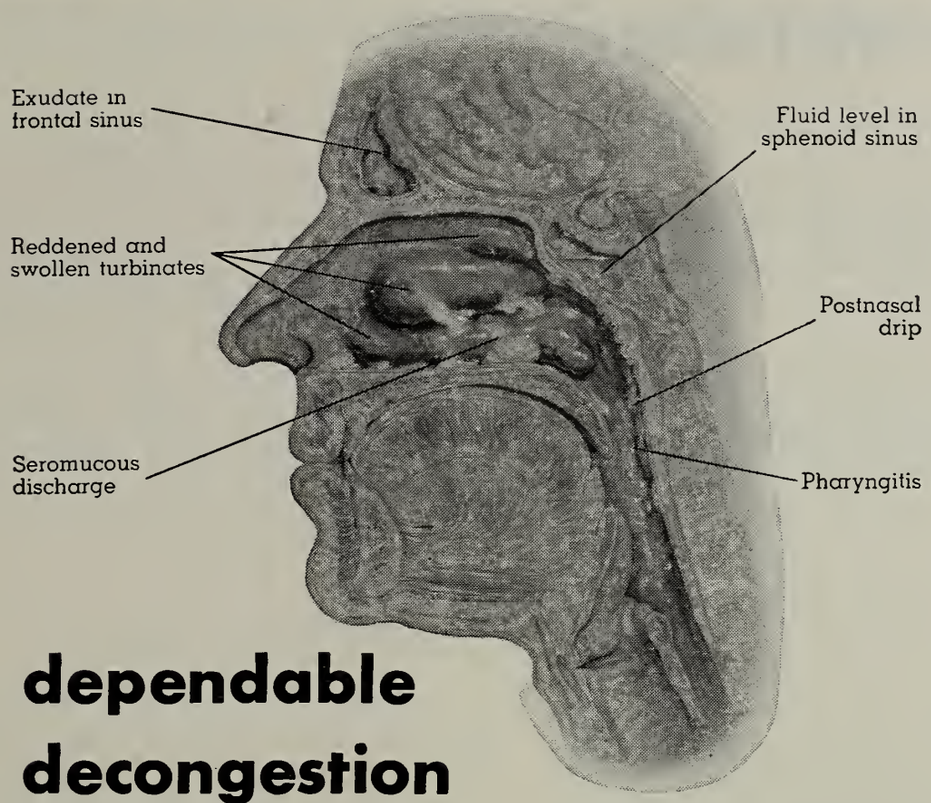
Dr. Borowski takes over his new post on January 1, to succeed Mrs. Jane B. Sherrill, who resigned. The present Barberton Citizens Hospital of 78 beds is being replaced by a new 246-bed building which will be ready for occupancy about September 1.

Farmer Leaves Ohio TB Association To Form PR Firm in Columbus

J. Edwin Farmer, public relations director for the Ohio Tuberculosis and Health Association, left the staff in November to form a public relations counseling firm. The new firm is the Capital Services Associates with offices at 17 S. High St., in Columbus.

Mr. Farmer joined the staff of the TB Association in December, 1945, following service in the U. S. Navy. Prior to his Naval service, he was executive director of the Columbus Tuberculosis Society beginning work with that organization in 1933.

Duncan R. Thorp, of Wisconsin, has joined the staff of the Ohio Tuberculosis and Health Association, as public relations director. He has had extensive experience in publications work, publicity, public relations and was active in the legislative program of the Wisconsin Anti-Tuberculosis Association.



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In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

DRIVE FOR MEDICAL SCHOOL FUNDS GAINING MOMENTUM

It looks as if the campaign to solve the financial problems of the medical schools through private resources is beginning to click.

The Committee on Industry of the National Fund for Medical Education reports that 125 gifts totalling $111,940 were received from corporations in November, 1953, as against three gifts amounting to $16,125 in November, 1952. The first eleven months of 1953 show 748 gifts equalling $1,096,634. The same period in 1952 showed 258 gifts totalling $678,952.

At the meeting of the House of Delegates of the American Medical Association in St. Louis, December 1, officials of the American Medical Education Foundation reported a total of $1,174,000 at that time. The 1952 total was $906,533.82 by 7,259 contributors. The number of contributors in 1953 more than doubled, based on incomplete figures as this was written.

The A. M. E. F. campaign in Ohio is gaining momentum too. As of November 30, 1953, contributions amounted to $18,126 from 360 subscribers. The total at the end of 1952 was $13,177 from 265 subscribers. This was in addition to 1,657 Ohio physicians who made contributions directly to the Alumni Funds of their own medical schools in 1952, a laudable performance which it is hoped they repeated in 1953.

Dr. David W. Heusinkveld, Councilor for the First District of the Ohio State Medical Association, recently came up with a "prescription" for the "financial ills" of the medical colleges. He proposed his plan in an address to the Cincinnati Academy of Medicine while presenting 50-year awards to five local physicians. Dr. Heusinkveld stated that of the approximately 200,000 physicians in the United States, at least 100,000 of them could afford to give $100 a year each in the cause of medical education. This would provide the comfortable sum of $10,000,000—enough to put the colleges solidly on their feet, Dr. Heusinkveld declared. In our opinion he's got something there.

DOCTORS AND CIVIC GROUPS GO INTO A HUDDLE

"We have embarked upon a new venture. For the first time in the history of the Tuscarawas County Medical Society we are having combined meetings with leaders of various civic groups."

The above comment was carried recently in the news letter sent by the Tuscarawas County society to its members.

If each county medical society would do likewise, many of the misunderstandings between the medical profession and people would evaporate.

Civic leaders can be mighty helpful in giving the public the facts about medicine, medical practice, etc. Naturally, they can't, and won't, bat unless they're asked to join the team. The doctors in Tuscarawas County have decided to do something about it.

OHIO WITNESSES BUREAUCRACY IN ACTION

One of the vicious aspects of bureaucracy is illustrated by the situation which has developed in Ohio with respect to the Federal aid program of care for the permanently and totally disabled. Here's a step-by-step account:

The Federal Government instituted the program, calling for Federal hand-outs to the states and providing that every county within a state must participate in order for the entire state to receive Uncle Sam's cash. Ohio's share is about $3,000,000 annually.

Harrison County decided against participating on the grounds that it is time to start doing away with some of the Federal hand-outs. Because of this, the program, according to Federal officials, can't start any place in Ohio.

State officials have been putting the heat on Harrison County officials. One newspaper reported that the state has threatened to withhold all state general relief matching funds from Harrison County unless it becomes a good boy and joins up for the other program.

This is not good. Doubtless there is a need for a program to care for the permanently and totally disabled in every county of Ohio. However, if Harrison County or any other county wants to do the job itself, why should the Federal Government try to force it to accept Federal hand-outs.

Why should a county which wants Federal aid be penalized because some other county rejects cash from Washington? Why should Ohio officials put pressure on local government officials to accept Federal grants? Doesn't the primary responsibility for looking after its needy citizens rest with local governmental agencies? If local areas are willing to assume that responsibility, why should they be told how to do the job and where to get the money to do it?

Obviously, Harrison County should provide ade-



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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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quate care for its permanently and totally disabled. The point is: It should not be compelled to accept anyone else's money if it can and is willing to do the job itself.

If legislation is required to correct this situation, Congress should act promptly.

Those who think Federal grants are such grand and glorious things should keep in mind that all of them have strings attached and take away from local governments the power and right to run their own affairs.

THANKS, TONY, FOR A GOOD JOB AND GOOD LUCK

As Dr. Anthony J. Borowski leaves the Ohio Department of Health where he served as chief of the Division of Hospital Facilities to take over the office of superintendent of the Barberton Citizens Hospital, now being extensively remodeled, he can view with a great deal of personal satisfaction the splendid record which his division made under his supervision.

Starting at scratch—in fact, less than scratch —the division under Borowski during the past six years has played a major role in initiating 70 hospital building programs in Ohio under the Federal Hill-Burton Act. The cost involved approximates $111,000,000. In addition Borowski and his aides have rendered valuable assistance to hospital building ventures outside the scope of the Hill-Burton Act.

Because of the good work of that division, Ohio can now boast of hospital facilities which are on a par with those of any other state, even though, as Borowski will readily admit, there still is plenty of spade work to be done. The citizens of Ohio owe him and his staff a vote of thanks and an expression of best wishes for success in his new work. Running the hospital at Barberton should be a picnic for Borowski in comparison to the merry-go-round which he has been riding for the past six years. Barberton is to be congratulated on having secured a thoroughly competent hospital administrator.

TO STUDY DOCTORS' ATTITUDES ON VOLUNTARY INSURANCE

You may be one of the Ohio physicians, picked at random, who will receive one of the questionnaires being sent out jointly by the Council on Medical Service and Bureau of Medical Economic Research of the A. M. A. to ascertain physicians' attitudes concerning voluntary health insurance.

If so, complete the questions to the best of your ability and return the blank promptly to the A. M. A. The following excerpts from an editorial on this subject in *The Journal of the A. M. A.* provides answers to the "why's" about the survey:

"With voluntary insurance programs of many types insuring increasing numbers of persons, the attitude of physicians is most important to its continued growth and success.

"There is no uncertainty about the attitude of the vast majority of practicing physicians concerning the relative merits of the many forms of voluntary health insurance over any compulsory tax scheme. Likewise, there is little doubt relative to the opinions of spokesmen for certain nonmedical and noninsurance groups concerning their attitudes about what voluntary insurance can and should accomplish.

"Many questionnaires and many opinion surveys have been designed since the advent of health insurance. None, apparently, has attempted to gather information that would indicate the attitude of physicians concerning certain aspects of voluntary health insurance. This is the purpose of the current survey.

"Health insurance, at times, is subjective. It has created a vocabulary comparatively new to many who have been interested in the topic. The same terms and phrases convey different meanings to different persons according to their own experiences or to the sources of their information.

"Among other things it is necessary to know to what extent insurance plans may affect the traditionally confidential relationship between the patient and the physician. The survey is also designed to learn how physicians feel about the extent to which insurance involves them in the realm of service benefits and in their financial relationships with patients and how they feel toward the different types of generally available insurance plans."

PLACEMENT SERVICE GETS PAT ON THE BACK

Recently the Physicians Placement Service of the Ohio State Medical Association, which operates out of the Columbus Office, received a letter which shows just how valuable this service is to physicians—and many communities of the state. The letter, with the name of the city and physician deleted, from the secretary of the city's Chamber of Commerce, read as follows:

"Last April you sent me a list of physicians registered with your office and placed ---------- on your list of towns needing additional doctors.

"I am pleased to tell you that a young physician is moving to ---------- within the next few days, ----------, M. D.

"We are fortunate in having available the office and full equipment of a former physician here which will be of great help to Dr. ---------- in getting established.

"You have been of immense help to us and I assure you that we do appreciate your kind cooperation and assistance."

No, the Physicians Placement Service of the O. S. M. A. can't perform miracles. Neither can it supply physicians for all areas which believe they should have a doctor or another one. Nevertheless, it is plugging along doing a rea-

ORAL PENICILLIN IS AT ITS BEST

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". . . the first oral preparation of penicillin which has in our experience been reliably absorbed in 100% of patients, irrespective of size and weight and using a standard dose of 300,000 units . . . [it] was given irrespective of the time of meals and whether the stomach might be full or not"[1]; . . . "may be given without regard to meals . . ."[2,3]

2 WHEN ITS THERAPEUTIC EFFECTIVENESS IS ESTABLISHED

"The results presented indicate that the oral penicillin suspension studied by us is a satisfactory antibiotic for the treatment of some of the common infections of the respiratory tract caused by β-hemolytic streptococci" . . . and uncomplicated pneumonias of childhood.[4]

3 WHEN PALATABILITY ASSURES PATIENT COOPERATION

Bicillin "oral suspension is palatable, was accepted without difficulty by all patients in both groups [children and adults] and was well tolerated."[2]

"No children of any age have been disturbed, and the palatability of the product has made its administration easy."[1]

4 WHEN STABILITY ASSURES RETENTION OF POTENCY

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REFERENCES

1. Cathie, I.A.B., and MacFarlane, J.C.W.: Brit. M. J. 1:805 (April 11) 1953.
2. Coriell, L.L., and others: Antibiotics & Chemotherapy 3:357 (April) 1953.
3. Barach, A.L.: Geriatrics 8:423 (August) 1953
4. Finberg, L., Leventer, I., and Tramer, A.: Antibiotics & Chemotherapy 3:353 (April) 1953
5. Editorial: Antibiotics & Chemotherapy 3:347 (April) 1953.

sonably good job and creating much good will for the Association, even though there are still a few critics who like to feel that some bogeyman is trying to keep doctors hidden away in dark cellars.

The letter quoted above indicates that the city involved did something to help itself get a doctor. It didn't just sit back and expect one delivered on a silver platter. Doctors have to have office space and a place to live. They want reasonably desirable social and economic environments; good schools and churches; recreational facilities, and other things which make a community a good place for raising a family. These items play a major role in getting physicians to locate in areas where there is a need.

Continuation Courses for Doctors Listed in A. M. A. Journal

The semiannual listing of postgraduate continuation courses for physicians, covering the period January 1 to July 15, 1954, appears in the December 12 issue of *The Journal of the American Medical Association.*

These data, prepared as a regular service by the Council on Medical Education and Hospitals of the A. M. A., list 1,034 courses varying in length from a few days to several months and extending to full academic years.

The subjects include 40 areas in the field of clinical medicine and eight basic science subjects.

Ninth District Holds Successful Meeting on Subject of Heart

A joint meeting of the Ninth Councilor District of the Ohio State Medical Association and the Ninth District of the Ohio Academy of General Practice drew an attendance of 52 at Jackson on December 3.

Active in arranging the meeting were Dr. Herbert D. Chamberlain, McArthur, member of the Board of the Ohio Academy of General Practice, and Dr. C. L. Pitcher, Portsmouth, Councilor of the Ninth District, Ohio State Medical Association.

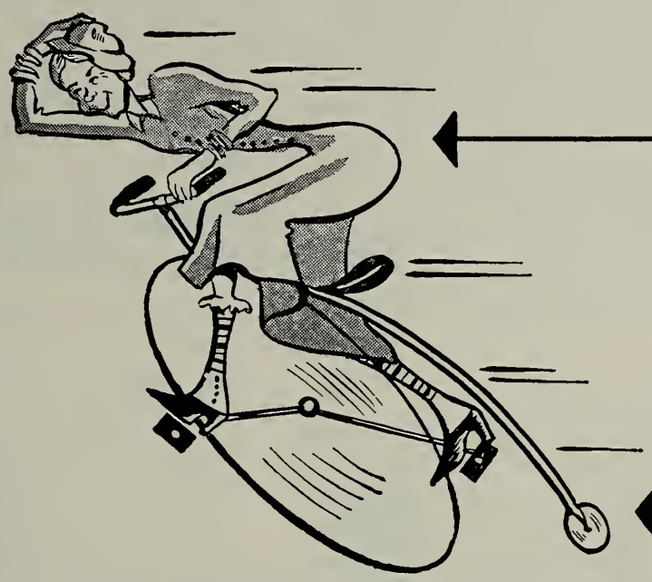
The postgraduate program on the "Heart" was conducted by a team from Ohio State University College of Medicine consisting of the following physicians: Drs. H. B. Hull, J. M. Ryan, L. A. Saperstein, J. F. Schieve, O. W. Hosterman, J. L. Morton and Karl P. Klassen.

The December 3 meeting was one of a series of postgraduate programs planned for the Ninth District under direction of the same sponsoring organizations. Future meetings will be announced as arrangements are made.





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In Memoriam . . .

Harry Webster Burnett, M. D., Dayton; Ohio State University College of Medicine, 1915; aged 61; died November 6; member of the Ohio State Medical Association; member of the American Medical Association, the Radiological Society of North America, the American College of Radiology; diplomate of the American Board of Radiology. Dr. Burnett practiced in Dayton for 38 years where, in addition to his private practice, he was on the consulting staff of Miami Valley Hospital. Affiliations included memberships in several Masonic bodies, the Methodist Church and the American Legion. Surviving are his widow, two sons, one of whom is Dr. Harry W. Burnett, Jr., of New York City; a sister and his mother.

Frank Dillon Campbell, M. D., Coal Grove; Miami Medical College, Cincinnati, 1894; aged 86; died November 6; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Campbell had practiced in Ironton and Lawrence County for 60 years, and several years ago had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a member of the Methodist Church. Surviving are a daughter and two brothers.

Frank Davies Conroy, M. D., Cincinnati; Johns Hopkins University School of Medicine, 1918; aged 60; died November 20; member of the Ohio State Medical Association through 1951. A physician in Cincinnati for many years, Dr. Conroy had retired.

Ralph Warren Faus, M. D., Wellington; Cleveland-Pulte Medical College, 1914; aged 61; died November 9; member of the Ohio State Medical Association and the American Medical Association. Dr. Faus practiced for 37 years in Wellington, where he was active in many community affairs. A veteran of World War I, he was active in the American Legion. He was also a member of the Forty-and-Eight, the Masonic Lodge, the Elks Lodge, the Methodist Church and Phi Alpha Gamma. Surviving are his widow, two daughters, a son, a step-son, a sister and two brothers.

George Seely Gilpin, M. D., San Francisco, Calif.; Washington University School of Medicine, St. Louis, 1912; aged 66; died November 24; member of the Ohio State Medical Association through 1951. A resident of Rocky River until about a year ago, Dr. Gilpin was plant physician for the Swift & Company plant in Cleveland, and served other industrial plants in the Cleveland area. During World War I, he was in service with the Army Medical Corps and was decorated by the French government for his work in the influenza epidemic. Surviving are his widow, two sons and a daughter.

Silas Edward Hendren, M. D., Dayton; Ohio Medical University, Columbus, 1900; aged 81; died November 23; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Hendren served all of his professional career in Dayton and had been honored with the 50-Year Pin of the Ohio State Medical Association. He was a member of the Lutheran Church, the Masonic Lodge, Alpha Mu Pi Omega and the Dayton Gymnastic Club. Surviving are a daughter, a sister and a brother.

Philip Jacob Holabach, M. D., Pullman, Wash.; University of Cincinnati College of Medicine, 1936; aged 44; died on or about November 17. Dr. Holabach left Cincinnati shortly after completion of his medical education. He had been practicing in Pullman since World War II.

Charles Everton Hunter, M. D., Mansfield; Starling Medical College, Columbus, 1902; aged 77; died November 22; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Hunter practiced for 15 years at Bellville before moving to Mansfield. He had been honored with the 50-Year Pin of the Ohio State Medical Association. He was a member of the Congregational Church. Surviving are his widow, a son, two sisters and a brother, Dr. F. J. Hunter of Gulfport, Fla.

Elvin Lorne Lowthian, M. D., Yorkville; Western Reserve University School of Medicine, 1908; aged 74; died November 1; former member of the Ohio State Medical Association, last in 1920. A long-time resident of Yorkville, Dr. Lowthian had not been in practice for some years. He was a member of the Masonic Lodge and the Episcopal Church. Surviving are widow, a son, a daughter and two sisters.

William Thomas Matthews, M. D., New Vienna; Medical College of Ohio, Cincinnati, 1910; aged 82; died November 30. Dr. Matthews started practice in Milledgeville in 1901 and two years later moved to New Vienna. He went into semi-retirement in 1948. Active in community affairs, he was a member of the Masonic Lodge and the Methodist Church. He also was a director of the New Vienna Bank. Surviving are his widow, two sons, one of whom is Dr. Charles W. Matthews, of Columbus; two brothers and two sisters.

John H. Murray, M. D., Carrollton; Chicago College of Medicine and Surgery, 1916; aged 63; died November 29; member of the Ohio State Medical Association; member of the American Medical Association; very active in the Carroll County

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Medical Society, being president and vice-president several times; also active as chairman and member of numerous local committees over a long period of time. A practicing physician for 33 years in Carrollton, Dr. Murray was active in numerous community affairs. He was a member of Phi Delta Theta, Phi Delta, the American Legion and the Presbyterian Church. During World War I, he served overseas in the Medical Corps. He leaves his widow, two daughters, a son who is a medical student at Western Reserve, a brother and three sisters.

Reed Albert Shank, M. D., Cincinnati; University of Cincinnati College of Medicine, 1916; aged 60; died November 26; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Shank served all of his professional career in Cincinnati. A lover of sports, he served as physician to the University of Cincinnati football squad and the Cincinnati Reds baseball club. He also served as a member of the Board of Directors of the University of Cincinnati, and at the time of death was chairman of the board's athletic committee. He also was a member of the faculty at the College of Medicine and a member of the Board of Trustees of Christ Hospital. During World War I, he served with the Medical Corps. Affiliations included the Methodist Church and numerous organizations. Surviving are his widow, two sons, a daughter, his mother and two brothers.

Christian Storz, M. D., formerly of Toledo; Wayne University College of Medicine, Detroit, 1891; aged 89; former member of the Ohio State Medical Association. *The Journal* has been informed that Dr. Storz died in Los Angeles, Calif., on June 25. He had retired in 1943.

Robert Frederick Thaw, M. D., Akron; Ohio State University College of Medicine, 1911; aged 69; died November 27; member of the Ohio State Medical Association and member of the American Medical Association; president of the Summit County Medical Society, 1944. A practicing physician in Akron for many years before his retirement, Dr. Thaw was a former member and chief of staff of the Children's and Akron City Hospitals. He also was a member of the Akron Health Commission, and during World War I served as captain with the Medical Corps.

Harry Wisner Wertz, M. D., Montpelier; Kentucky School of Medicine, Louisville, 1890; aged 84; died November 12; member of the Ohio State Medical Association and member of the American Medical Association through 1952; Delegate of the Williams County Medical Society to the Ohio State Medical Association for more than 15 years. A life resident of Williams County, Dr. Wertz practiced his profession for 60 years before his retirement three years ago. He had been honored with the 50-Year Pin of the Ohio State Medical Association. He served in various public capacities, being county coroner, member of the county board of health, member of the Montpelier board of education, village health officer, county health commissioner and surgeon for the Wabash Railroad. During World War I, he served as captain in the Medical Corps, and was a member of the American Legion. He also was a 32nd degree Mason. His widow survives.

Initial Medical License Fee Not Deductible on Tax Return

In the Tax Roundup story for physicians which appeared in the December issue of *The Journal* it was broadly stated, under "deductible business expenses," that "all license fees which the physician is required to pay, including narcotic tax and local occupational taxes, are deductible."

A reader has called attention to an exception. Fees and expenses paid for "securing the right to practice" are not deductible. In other words, the initial fee paid to secure a license to practice in the State is not deductible as business expense.

Five-Year Limitation on GI Term Insurance Lifted

Some four million veterans with National Service Life Insurance term insurance in force will no longer have to apply to the Veterans Administration for renewal of the policies for another five year term before their old policies expire.

The V. A. will do this for them automatically, if their old policies are not lapsed at the expiration of the term period. This means the policy must be in force at the end of the term period with the final premium having been paid on time.

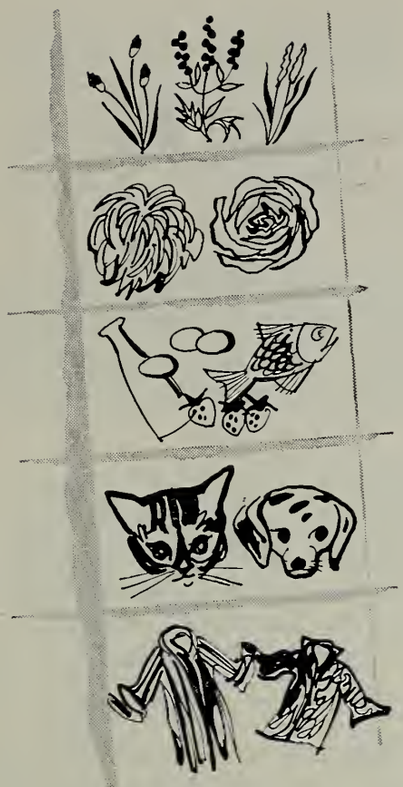
The new procedure went into effect July 23, 1953, when the President signed Public Law 148. The new law covers only those term policies that expire on or after July 23, 1953.

Congress on Medical Education To Meet in Chicago

The Fiftieth Annual Congress on Medical Education and Licensure will be held on Monday and Tuesday, February 8-9 at the Palmer House, Chicago, under auspices of the Council on Medical Education and Hospitals of the American Medical Association and the Federation of State Medical Boards of the United States.

On February 7 there will be an open meeting of the Advisory Board for Medical Specialties.

Those who plan to attend should write directly to the Palmer House (or other hotel of choice) for room reservations mentioning the meeting they are attending.



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Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

REORGANIZATION of National Red Cross creates a new salaried position of president at $30,000 a year. The new president, Ellsworth Bunker, will take over full administrative responsibility from former president, E. Roland Harriman, who has served without pay since 1950. Harriman will continue as chairman of the board, which office will remain as an appointment of the President of the United States.

* * *

Public Health Service reports incidence of scarlet fever and streptococcal sore throat in the U. S. has been increasing for several months. However, rate of increase has been slower than for the same period last year.

* * *

The Federal Trade Commission has announced that it is going to launch a national investigation of frauds in mail order insurance, including health insurance.

* * *

A panel of consultants to the Manion Commission (on federal-state relationships) has started a national survey to "determine the composite impact of all federal aid programs in the state and local fields where the service is rendered." It will look into all programs where both federal and state or local funds are used, including vocational rehabilitation, grants for crippled children work, and others.

* * *

Nebraska is winding up its five-year medical care program for public assistance recipients and is turning it over to the counties because of federal "meddling." The state's problem was outlined by two witnesses before the House Ways and Means subcommittee fact-finding hearing on social security. The core of the problem, they testified, was insistence of the Bureau of Public Assistance that since federal funds provide the foundation of welfare programs, all related programs should conform to federal regulations.

* * *

Federal Trade Commission announces approval of stipulations that will result in modification of medical claims for sun lamps and arch supports. Cincinnati firm of Sperti Faraday, Inc., will stop advertising that use of its lamps promotes body resistance to colds. Scholl Manufacturing Company of Chicago will stop representing that its foot aids are universally indorsed by the medical profession and that they are useful in relief of varicose veins.

Dr. Wallace M. Yater, former president of the District of Columbia Medical Society, has been named to the National Advisory Health Council which advises the Public Health Service on grants from the National Microbiological Institute.

* * *

Consumer costs for medical care, including hospitalization and certain drugs, rose two-tenths of one per cent in October according to latest price index of the Labor Department. Increase was attributed mainly to higher fees for professional services.

* * *

In the opinion of the U. S. Chamber of Commerce, Congress has "lost control of the purse strings," because its two under-staffed appropriations committees are "unable to examine carefully the thousands of budget items or to decide which is really justified." The Chamber is proposing that the staffs of the two appropriations committees be increased to make possible more thorough examination of the budget, and that the Executive Branch with its vast army of employees working on budgets be reformed to "place more emphasis on cost-consciousness."

* * *

Federal Trade Commission complaint against Institute of Applied Hypnology, New York, disputes advertised promises that its mail order course in hypnotism qualifies graduates to treat epilepsy, obesity and alcoholism.

* * *

Chairman Daniel A. Reed, (R., N. Y.) of the House Ways and Means Committee, has indicated that in his opinion, Congress should not force mandatory social security coverage on physicians and others who don't want it.

* * *

Office of Rep. Frances P. Bolton (R., Ohio) reports good early response to her questionnaire survey on nursing resources. Ten days after the last of 10,000 blanks had been placed in the mail, 15 per cent had been returned.

* * *

A recently issued report by Television Code Review Board of the National Association of Radio and Television Broadcasters expresses high satisfaction with cooperation and constructive criticism by the A. M. A. toward improvement of programs in which physicians are portrayed.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

BUTLER

Dr. Louis H. Frechting was honored at dinner meeting of the Butler County Medical Society when he was presented the 50-Year Pin of the Ohio State Medical Association. The presentation was made by Dr. David H. Heusinkveld, Cincinnati, Councilor of the First District of the Association. Presiding at the meeting was Dr. W. F. Hume, president.

Speaker for the occasion was Dr. William A. Altemeier, University of Cincinnati College of Medicine, who presented an illustrated talk on "A Medical Trip to the Korean War Front."

CLERMONT

Dr. F. M. Oxley, Batavia, was elected president of the Clermont County Medical Society at the annual meeting in November. Dr. Oxley is health commissioner for Clermont County.

Dr. James MacMillian, Milford, was elected vice-president; and Dr. John T. Crone, also of Milford, was elected secretary-treasurer to succeed Dr. J. M. Coleman, Loveland, who has held the office for 20 years. Dr. Coleman was commended for his long and faithful service by a resolution of the Society.

CLINTON

Dr. Nathan Hale spoke on "Varicosities and Thrombophlebitis," at November 3 luncheon meeting of the Clinton County Medical Society in the General Denver Hotel.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

CLARK

Dr. J. H. Rinehart was installed as president of the Clark County Medical Society at the annual meeting in the Shawnee Hotel, Springfield, on November 16.

Dr. C. W. Hullinger was named president-elect. Dr. E. W. Winterhoff and Dr. J. A. Davidson were elected secretary and treasurer, respectively, for two-year terms.

Principal speaker for the occasion was Dr. R. M. Zollinger, Columbus, chairman of the Department of Surgery, Ohio State University College of Medicine, whose topic was, "Surgical Indications in Jaundiced Patients."

MIAMI

Members of the Miami County Medical Society took a leading role in the dedication of new Dettmer Hospital between Piqua and Troy, on December 6, when more than 6,000 persons visited the new institution. The Medical Society and the County Commissioners are jointly responsible for appointment of the hospital's board of governors.

The hospital, intended for the care primarily of chronic and convalescent patients, was built by a bequest of the late Jacob Dettmer, baking powder manufacturer. Intent of the board of governors, as reported in local newspapers, is that the new hospital will supplement services of the Piqua Memorial Hospital and the Stouder Memorial Hospital, Troy.

MONTGOMERY

Two feature speakers were guests at the December 4 meeting of the Montgomery County Medical Society in Dayton. Dr. Warren E. Wheeler, professor of pediatrics and bacteriology, Ohio State University College of Medicine, spoke on "Treatment and Prevention of Acute Rheumatic Fever." Dr. Joseph M. Ryan, assistant professor of medicine at Ohio State, spoke on the subject, "Treatment of Chronic Rheumatic Heart Disease." The program was sponsored by the Pediatric Section and the Internal Medicine Section of the Society.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

Dr. James A. Dickson, head of the Orthopedic Department of the Cleveland Public Health Clinic, addressed the Academy of Medicine of Lima and Allen County on November 17. He discussed the treatment of various types of fractures.

On December 15 a dinner dance was held at the Lima Country Club.

AUGLAIZE

Dr. F. F. Fledderjohann, New Bremen, was honored by the Auglaize County Medical Society by being presented the 50-Year Pin and Certificate of the Ohio State Medical Association.

Member of a pioneer family of the county, Dr. Fledderjohann returned to New Bremen upon completion of his medical education at Jefferson Medical College, and has practiced in that community since. A public recognition dinner was given for him in New Bremen this summer in recognition of his 50 years of medical service to the community.

CRAWFORD

The Crawford County Medical Society held a special meeting for those interested in the techniques of filing Ohio Industrial Commission forms. Doctors assistants, hospital personnel and

those doing industrial work in industrial firms as well as physicians were invited.

Speaker was C. C. Grubbs, assistant director of the Claims Division of the Ohio Industrial Commission.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The following program features were listed by the Academy of Medicine of Toledo and Lucas County for November:

General meeting, November 6, panel discussion on indoctrination of new members.

Section of Pathology, November 13, "Accuracy of Laboratory Methods," Dr. J. G. Snavely, pathologist, Maumee Valley Hospital.

Medical Section, November 20, "Recent Advances in Roentgen Study of Cardiac and Vascular Systems," Dr. Melvin M. Figley, assistant professor of radiology, University Hospital, Ann Arbor, Mich.

Gatherings to view the special color television programs of the American Cancer Society were held on November 4 and November 18. The respective subjects presented were "The Significance of Cough," and "Cancer of the Prostate."

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

CUYAHOGA

The sixteenth annual Lower Lecture was given by Dr. John Jones, professor of surgery at the University of Southern California on November 20 at the Medical Library Auditorium. His subject was "Present Status of the Surgical Treatment of Congenital Lesions of the Heart and Great Vessels."

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

The Belmont County Medical Society and the Auxiliary held a dinner meeting at the Belmont Hills Country Club on December 17. Dr. J. H. Carson was in charge of the program committee which selected a medical film for the program.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

DELAWARE

Dr. W. E. Borden and Dr. F. M. Stratton, both of Delaware, were presented 50-Year Pins of the Ohio State Medical Association at a meeting of the Delaware County Medical Society.

FRANKLIN

Dr. Henry L. Bockus, professor of gastroenterology and vice-dean of internal medicine, Graduate School of Medicine, University of Pennsylvania, spoke on the subject, "The Mechanism of Abdominal Pain," at the November 16 meeting of the Columbus Academy of Medicine.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

Dr. Clifford L. Kiehn, Cleveland, was guest speaker at the December 8 meeting of the Lorain County Medical Society in the Spring Valley Country Club, Elyria. His subject was "Cancer of the Oral Cavity."

RICHLAND

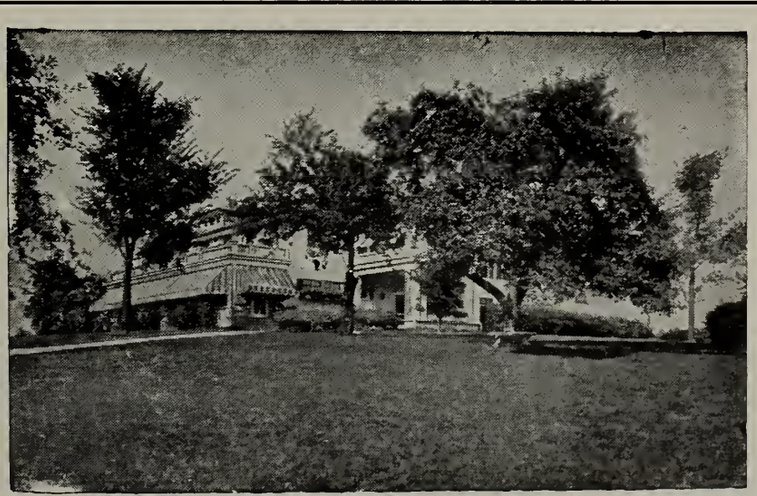
On November 19, approximately 55 members of the Richland County Medical Society met at the Westbrook Country Club, Mansfield, for their regular monthly meeting.

Following dinner and a business meeting, the program was presented by three members of the staff at Henry Ford Hospital, Detroit, Mich. The speakers and their subjects were as follows:

Dr. L. S. Fallis, "Gastric and Gall Bladder Surgery."

Dr. James Barron, "New Approach to Postoperative Nutrition."

Dr. Edward Munnell, "Repair of Large Hernias."



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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), Lancet *2*:1002 (Dec. 1) 1951.

2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, Mississippi Doctor *30*:359 (Apr.) 1953.



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Activities of Woman's Auxiliary . . .

By MRS. EDWARD L. VOKE, Chairman, Publicity Committee, 243 Hampshire Road, Akron 13, Ohio

President—Mrs. N. M. Reiff, 404 Rawlings Street, Washington Court House

President-Elect—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13

Vice-President—Mrs. O. W. Jepson, Bowen Road, Canal Winchester

Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge

Corresponding Secretary—Mrs. James E. Rose, 729 Washington Avenue, Washington Court House

Treasurer—Mrs. Karl Ritter, 1420 Shawnee Road, Lima

Past-President—Mrs. Paul M. Woodward, 1500 Hollywood Avenue, Cincinnati 24

BOARD MEETING

Mid year Board meeting will be January 12, 1954, at the Fort Hayes Hotel, Columbus, 9:30 A. M.

A. M. E. F.

Mrs. George W. Cooperrider reported that 13 additional County Auxiliaries have contributed to American Medical Education Foundation. They are: Allen, Butler, Columbiana, Darke, Greene, Guernsey, Hardin, Huron, Jefferson, Knox, Lucas, Trumbull, and Tuscarawas.

WOMEN'S CLUBS AWARD OHIO CITATION TO MRS. PITCHER OF PORTSMOUTH

Mrs. Carter L. Pitcher, of Portsmouth, has been cited as the Ohio Federation of Women's Club's "One-Hundred Per Cent Citizen" for the year. The award was made on nomination of the Ohio organization by the General Federation of Women's Club, an international organization.

Mrs. Pitcher is the wife of Dr. Carter L. Pitcher, Councilor of the Ninth District of the State Association, and mother of two sons, one a student at Ohio State and the other a high school student.

The award was made on the basis of service to the community through the following activities and achievements:

Past-president, Junior Women's City Club;

Chairman of recruitment, Red Cross blood donor program;

Vice-president and board member, Scioto County Tuberculosis and Health Association.

Four times president and board member of the Fresh Air Camp for underprivileged children;

Former chairman of Dental Health Committee, Ohio State Parent-Teacher Association;

Past-president, Woman's Auxiliary to the Scioto County Medical Society;

Representative board member, Scioto County Community Chest;

Active member of First Presbyterian Church of Portsmouth and the Woman's Association of that church.

The citation was presented at a recent meeting of the Junior Woman's City Club of Portsmouth.

ASHTABULA

Ashtabula County Auxiliary announces its new officers for the year as follows: President, Mrs. Carl J. Streicher; vice-president, Mrs. William Eberle; president-elect, Mrs. Perry Longaker; secretary, Mrs. J. Richard Nolan; and treasurer, Mrs. Arthur Shaul.

The annual money-raising project to support the nurse scholarship fund this year was a Charity Ball held in December. Mrs. James Macaulay and Mrs. Jason Dixon were co-chairmen for the dance with Mrs. Carl Streicher and Mrs. Frank Veroni on the committee. Mrs. Gordon Jones, chairman of the Decorating Committee will be assisted by Mrs. Byron Johnson, Mrs. Wm. Eberle, Mrs. Charles Suttles, and Mrs. E. N. Wright.

BUTLER

At the November meeting, Mrs. Richard Vieter of Cincinnati spoke on the A. M. E. F. at the First Presbyterian Church. Mrs. Kenneth Smith headed the hospitality committee. Others on the hostess committee were Mrs. Rodney Caudill, Mrs. Wm. Storer, and Mrs. J. M. Anderson.

FAIRFIELD

Mrs. Lester Peters, the guest speaker, at the last meeting, delighted the Auxiliary members with her clever, interesting, and varied flower arrangements. Mrs. Fred Spangler, the president had charge of the business meeting, held in the Pine Room of the Hotel Lancaster. Hostesses for this meeting were Mrs. R. S. Bode of Rushville, and Mrs. C. B. Snider and Mrs. W. H. Taylor of Pickerington. The group voted to give another $300 scholarship to a student nurse and to contribute to the A. M. E. F. Mrs. M. E. Nichols, Public Relations Chairman reported that the group assisted their husbands at a Booth at the Lancaster-Fairfield County Fair for four days this season.

FAYETTE

Members of the Fayette County Auxiliary assembled at the home of Mrs. Robert Woodmansee, for the regular monthly meeting. The president, Mrs. James E. Rose, called the meeting to order and plans were made to entertain the medical auxiliaries and husbands from seven southern counties of Ohio, on December 9, at a dinner party at the Washington Country Club.

Mrs. N. M. Reiff introduced Mrs. Frank Stevenson of Cincinnati chairman of nurse recruiting for Ohio, who spoke on the recruiting of nurses and Mrs. Paul Woodyard of Cincinnati, past-president of the State Auxiliary, was also introduced to the members by Mrs. Reiff.

The program was made up of interesting demonstrations in sewing, by Mrs. Urcel Hays,

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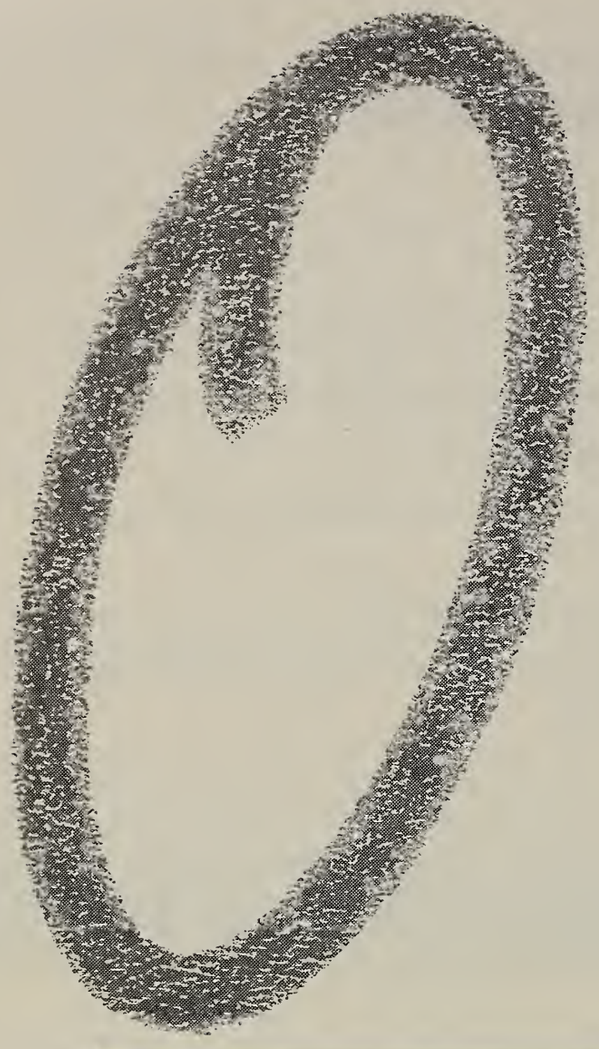
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FRANKLIN

A group of young women interested in nursing and their mothers were honored recently at a tea by the Franklin County Auxiliary Members. Dr. and Mrs. James Rodabaugh, co-authors of *Nursing in Ohio, a History*, and published this year were the speakers. Guests included the superintendents of Columbus nursing schools, the school nurses of Franklin County, the president of the Student Nurse Association, and the three student nurses who are receiving scholarships from the Auxiliary.

Mrs. Robert E. Pickett, Nurse Recruitment chairman, Mrs. Ann Gallagher, Columbus Nursing Council president, and the Nurse Recruitment Committee of the Auxiliary were in charge of arrangements. Mrs. Fred J. Ebstein and her social committee served tea. Name tags were made for the members and guests by Mrs. Joseph Leach. Mrs. Mel A. Davis, program chairman, introduced the speakers.

GUERNSEY

Christmas preparations took the place of the program when members of Guernsey Auxiliary were entertained at luncheon at the home of Mrs. Howard Van Noate.

Members brought a variety of gaily wrapped gifts to the meeting which they had provided for residents of the Guernsey County Home and prepared gifts while there, for the Children's Home. The balance of the time was spent in decorating boxes which were to be used in connection with the home-made Christmas cookie sale, which the Auxiliary scheduled for December 18 at the Ohio Fuel Gas Co., for the benefit of its student nurse fund.

HAMILTON

"Why Do You Worry" is the title of a program put over the air on Saturdays by the Auxiliary and station WKRC. This service was first started by Mrs. Carl H. Wendel, in 1951. She has been succeeded by Mrs. Paul N. Jolly and Mrs. Edward L. Dulle.

In the last election 11 Auxiliary workers, who became notaries public recognized by the Board of Elections, mailed 181 valid votes, 176 by hospital patients and five by shut-ins. They worked with disabled voters in nine hospitals.

They did more than a notary's work in seeing that a disabled voter's ballot was cast validly.

They contacted patients in the hospitals. They took to them the ballot applications. They notarized the application and certificate-of-physician. They were present, after the ballot was received from the Board of Elections, when the disabled voter placed the ballot in an "identification envelope," signed and swore to the affidavit

on this envelope and placed the "identification envelope" in the "return envelope."

Mrs. Earl C. Van Horn was named chairman of the annual dinner dance. The party is sponsored annually for the benefit of an educational and philanthropic fund, and is for members and their husbands only. The following members composed her committee: Vice-chairman, Mrs. William F. Hunting, in charge of reservations; Mrs. Herbert Brinker, chairman of decorations; and Mrs. John W. Devaney, Jr., treasurer. Mrs. Ralph W. Eddy head of committee to make boutonnieres; Mrs. Nicholas J. Giannestras, chairman of refreshments, with Mrs. Lloyd E. Larrick as vice-chairman; Mrs. Harry K. Hines head of entertainment; Mrs. Daniel V. Jones, chairman, and Mrs. William L. Roch, vice-chairman, of the invitation list.

Mrs. Edgar H. White was placed in charge of orchestra arrangements; Mrs. Joseph Lindner, chairman of the hostess committee; and Mrs. Gaston Hannah, acting as adviser. Mrs. Carl H. Wendel was given charge of publicity.

HURON

The November meeting of the Huron County Auxiliary was held at the home of Mrs. John V. Emery, of Willard. Following a dessert luncheon the business was conducted by Mrs. T. H. Smith, President. After a brief history on the communities represented, a silent auction was held.

LICKING

The Auxiliary recently presented for all girls in the Newark High School a program featuring nursing and its allied fields. Mrs. Carl Petersilge, the president, introduced the speakers. A film, "This Way of Nursing" was followed by discussions by Mrs. Margaret Walters, director of nursing at Newark Hospital, and Mrs. Dale Rath of the Nurse Recruitment Committee. The program was arranged by Mrs. Wm. Wills, chairman of the nurse recruitment committee.

At the November meeting in the home of Mrs. Wendell Steele sewing was done for the Red Cross, and New Year's Eve party hats were made for the veterans at Chillicothe Veteran's Hospital.

Mrs. William Wells reported on the three recent nurse recruitment programs in the school assemblies. Mrs. Carl Petersilge, Mrs. Dale Rath, Mrs. J. R. Wells, and Mrs. Paul Grove assisted her.

LOGAN

Mrs. Mills, the president, conducted the meeting of the group held at the home of Mrs. C. K. Starzman. A report on the recent tea for prospective nurses was reported upon.

Members of the Woman's Auxiliary of the Logan County Medical Society entertained at a tea recently in the nurses dining room at Mary Rutan hospital.

Invited guests were Sophomore girls in Bellefontaine and Logan county high schools inter-



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ested in the nursing profession and more than 100 responded.

A tour of the hospital was first enjoyed, then the group were assembled in the lounge where Mrs. Warren F. Mills, Auxiliary president, introduced Robert Kashner, hospital administrator, Mrs. Mary Jo Elswick, superintendent of nurses, and Miss Marjorie Sanderson, director of nursing at Miami Valley hospital, Dayton, who addressed the girls on the many phrases of nursing.

Punch and cookies were served. Mrs. J. P. Harbert presided at the tea.

Hostesses present included Mesdames Mills, Harbert, George Freetage, Fred W. Kaylor, John B. Traul, Bellefontaine, Douglas Beach of Huntsville, R. A. Firmin of Zanesfield, Hobart L. Mikesell of West Liberty, Charles H. Thompson of West Mansfield and Alwin E. Shultz of Russells Point.

LORAIN

Eugene Porter, Lorain County Health Educator, presented the November program for the Auxiliary, which met in Elyria's Spring Valley Country Club. Mrs. Theodore Finnegan, Elyria president, conducted the business meeting. Plans were completed for a formal dinner dance. Mrs. James Christie, also from Elyria, explained the muscular dystrophy program begun this fall in Lorain County. During the social hours Mrs. George Blank and Mrs. T. L. Smith were winners of the Pandora Box.

LUCAS

Dr. Wendell Green, president of the Academy of Medicine of Toledo and Lucas County, and Mrs. Green and Mrs. Boni Petcoff, president of the Auxiliary, and Dr. Petcoff were honor guests at the annual supper dance sponsored by the Toledo Dental Society.

At the November meeting, Grove Patterson editor-in-chief of *The Blade*, was the guest speaker. His topic was "Reporter Abroad." Mrs. O. H. Stone and Mrs. F. V. Gipson were in charge of the luncheon. Mrs. William Mewborn was chairman of the social committee.

Assisting her were Mesdames H. D. Cook, G. M. Todd, O. C. Keller, Brian Bradford, T. H. Brown, Jr., R. L. Zucker, Harold Shapiro, R. D. Simon, D. H. Black, S. Mignerey, M. V. Selman, L. S. Kahler, D. K. Levin, G. M. Swoyer, Mervin Green, H. C. Gunderson, W. H. Eyster, Jr., A. R. Klopfenstein, E. J. Singer, J. B. Rayman and E. L. Gaspari.

Two hundred members of the Future Nurses' Clubs of the high schools in the Toledo area were guests at a tea given by the Auxiliary in the Medical Building. Mrs. Myron Means and Mrs. L. S. Pugh, nurse recruitment committee chairmen, were in charge of the entertainment. Mrs. Boni Petcoff, president, spoke for the development of the Toledo Future Nurses' Clubs. Dr. Wendell Green, academy president, spoke



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for the local organization, and Dr. E. J. McCormick, president of the A. M. A., for the National organization.

There was a display of nurses' caps, earned by Auxiliary members, with Mrs. William H. Meffley in charge, aided by Mrs. Martin Lorenzen.

Mrs. Joseph B. Westhoven and Mrs. E. Forrest Ward assisted club representatives in the organization of their Inter-School Council. Registration of guests was handled by Mrs. George Bates, Mrs. I. W. McConnell and Mrs. John D. Burnett.

Arrangements for the tea was in charge of Mrs. David M. Katchka, of the nurse recruitment committee, and Mrs. William M. Mewborn, chairman of the social committee.

Presiding at the tea table were Mesdames Edward J. McCormick, Wendell W. Green, A. Paul Hancuff, E. Benjamin Gillette, Petcoff, F. W. Clement, Myron Means and Pugh.

The Mental Hygiene Study Group met at the home of Mrs. E. J. Singer. Mrs. Henry Hartman, the chairman presented Dr. Jack Schechter who spoke on "You and Your Personality." Mrs. John Buck, Mrs. Jonas B. Rayman, and Mrs. I. R. Cohn assisted with tea.

The child development study group with Mrs. William Phillips as chairman met at the home of Mrs. Robert L. Willard. Mrs. Wendell Schlecting led the discussion on "A Healthy Personality for Your Children." Mrs. Richard G. Hotz, chairman of the health committee, entertained her committee at a coffee hour recently in her home. Those attending were Mesdames John Dickie, Jack W. Millis, David C. Frick, Martin Lorenzen, J. E. Minns, Hazen L. Hauman, E. J. Singer and Boni E. Petcoff, Auxiliary president.

Mrs. E. A. Ockuly, Auxiliary representative to the City of Toledo Women's Traffic Council, arranged for a visit of Auxiliary Members to the Municipal Traffic Court. Mrs. Robert Curl is chairman of the Go-See Study Group.

The Live Issues of Today study group met at the home of Mrs. David T. Curtis. Mrs. Henry D. Beale led a discussion on "Iran" with Mrs. Paul Bell and Mrs. Frank J. Vykouk participating.

Mrs. John F. Buck was recently written up in the *Toledo Blade* in the "Meet a Club Leader" series. Mrs. Buck, serving for the second year, is co-chairman of the Lucas County Mothers' March on Polio Drive.

MAHONING

Almost $1,000 was realized for the nurses scholarship fund at the recent benefit dance given by the Auxiliary at the Squaw Creek Country Club. Mrs. I. Firestone was the party chairman assisted by Mrs. Alfred Cukerman and Mrs. Ivan Smith.

During Diabetic Detection week Mrs. W. B. Hardin was chairman of a committee to distribute

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GYNECOLOGY—Intensive Course, two weeks, starting Feb. 15. Vaginal Approach to Pelvic Surgery, one week, starting March 1.

OBSTETRICS—Intensive Course, two weeks, starting March 1.

MEDICINE—Electrocardiography & Heart Disease, two weeks, starting March 15. Two-Week Intensive Course starting May 3. Gastroscopy, two weeks, starting in March.

DIAGNOSTIC X-RAY—Two-Week Didactic & Clinical Course starting Jan. 4, March 1. Clinical Courses every week by appointment.

UROLOGY—Intensive Course, two weeks, starting April 19. Ten-Day Practical Course in Cystoscopy every two weeks.

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literature. The Auxiliary made a contribution to the fund for the Christmas party for patients at the Woodside Receiving Hospital.

MIAMI

Mrs. N. M. Reiff, president of the State Auxiliary, spoke on socialized medicine at the December meeting of the Auxiliary in the Piqua Country Club.

OTTOWA

Dr. and Mrs. W. H. Duffendock, Genoa, entertained members of the Ottowa County Medical Association and Auxiliary. Dr. Richard Waite of Tiffin spoke on their mental Health Clinic. The Auxiliary reported on work done on the County T. B. Association. Plans were made for making favors at Magruder Hospital.

SANDUSKY

Mrs. A. P. Newman, the president, welcomed members' wives of the county dentists, and friends of members when Don H. Wall of the United States Glass Co., in Tiffin, spoke on "Craftsmanship in Glass" in the board room of the Memorial Hospital.

Hostesses were Mrs. R. C. Fox, Mrs. W. H. Booth, Mrs. H. A. Yost, and Mrs. L. A. Pokerr.

SHELBY

At the November meeting of the Auxiliary held at the home of Mrs. Velma Paul in Batkin, the program was made up of current events presented by each member. Plans were completed for the Christmas meeting.

STARK

Proceeds from the annual benefit dance held in November amounting to $900 were added to the nurse scholarship fund by the Stark County Auxiliary. The announcement was made at the November meeting of the group held in Canton Woman's Club. Mrs. M. E. Stillwill of Alliance and Mrs. H. P. Ramsayer and Mrs. J. E. Kling of Massillon handled the ticket sales in those cities, respectively. Mrs. Francis C. Bayer, general chairman of the benefit, was assisted by Mrs. Cleon C. Couch, decorations; Mrs. Sidney Larson, co-chairman; and Mrs. Harold J. Bowman, ticket chairman. Miss Ruth Lehmiller, the guest speaker at the meeting, gave a talk on "White House Personalities." Mrs. I. H. Fuhs served as chairman for the luncheon.

SUMMIT

The Summit County Auxiliary was entertained at tea by the Akron District Heart Association in the new Seiberling Memorial Health Center.

Mabel M. Riedinger, Ph. D., associate professor of education at Akron University and Heart Association president, explained the goals and aims of her group following a tour of the seven health agencies of the Center.

Pouring at the tea table were Dr. Reidinger and Mrs. Norman D. Wentsler, Auxiliary president.

The annual Christmas luncheon was highlighted by carols presented by the Junior Glee Club of the Summit County Children's Home, and an address by Dr. Paul L. McKay of the First Presbyterian Church, "Reflections of the Modern Mood." Mrs. Walter H. Brown, social chairman, arranged the luncheon.

In a recent article in the local newspaper, Mrs. Edward L. Voke, the immediate past-president of the Auxiliary and chairman of the publicity committee for the State Auxiliary, was honored as an outstanding Akron woman. Her contribution to the community was in the public child welfare field. The article pointed out that Mrs. Voke was able to concentrate much time on her favorite project because of her inability to perform routine household tasks due to a rheumatic heart disability.

TRUMBULL

The Trumbull County Medical Auxiliary held its November luncheon meeting at the Trumbull Country Club. The speakers had as their subject, "The Different Phases of Orthopedics and Civilian Defense."

Dr. E. E. Bauman spoke on fractures of the legs and hips; Dr. R. J. Willoughby on fractures of the hands, arms and shoulders and Dr. Aubret Sparks on equipment needed for fractures.

Money was donated to the Warren Community Chest and a check sent to the American Medical Education Foundation.

A clothes dryer is being purchased for the Nurses Home at the Trumbull Memorial Hospital.

TUSCARAWAS

The Auxiliary's November meeting was held at the home of Mrs. P. T. Doughten Brightwood, with Mrs. E. C. Davis, Mrs. J. E. Hahn, Mrs. Wm. Hudson and Mrs. T. Ceremella as co-hostesses. During the meeting it was voted to give $25 to the A. M. E. F. "Nurse Recruitment" was the program subject for the meeting. Mrs. Robert Rinder Knecht, chairman of Nurse Recruitment, explained the purposes of Future Nurses' Clubs. Mrs. James O. Epps, school nurse at Massillon and Miss Lillian Jenkins, director of the Nurses' Training School at Massillon City Hospital, each contributed to the program.

UNION

At the October meeting of the Auxiliary Mrs. Priscilla Boylan, R. N., of the Union County Health Department explained the services performed by the department. She urged support in the coming election for the proposed health levy.

The Auxiliaries of Delaware, Knox, and Morrow Counties were entertained in November by the Union County Auxiliary. The guest speaker, introduced by the program chairman, Mrs. James

Snider, Marysville, was Mrs. George W. Cooperrider of Columbus, chairman of the A. M. E. F. for the State Auxiliary and program chairman of the National Auxiliary. Mrs. Oscar Winchester of Canal Winchester, vice-president of the State Auxiliary, was also a guest. The table decorations were arranged by Mrs. Fred Callaway.

VAN WERT

The Van Wert Auxiliary, recently reorganized, held its monthly meeting and announced its officers for the year, and its program.

As one phase of the program, representatives of county health agencies will be speakers at meetings.

The officers are Mrs. F. A. McCommon as president; Mrs. R. W. Ayres, vice-president; Mrs. C. A. Morgan, secretary-treasurer; Mrs. J. R. Jarvis, program chairman; Mrs. R. H. Good as ways and means chairman; Mrs. H. D. Underwood and Mrs. C. A. Morgan, constitution co-chairmen; Mrs. J. H. Cox, public relations chairman.

Miami (Fla.) Society Conducts Plaque Poll

Universal display of the A. M. A. plaque, "To All My Patients," in doctors' offices was recommended by the majority of the Miami, Fla., physicians responding to a recent informal poll conducted by the Dade County Medical Association.

Many favorable comments on the plaque were received from physicians whereas only one doctor gave a definitely unfavorable response. Typical patient comments noted by these physicians ranged from "a good idea" to "glad to see we have a humanitarian amongst the profession." Only one doctor reported a negative patient response which implied that medicine is "becoming too commercialized."

This poll brings out the fact that most patient fee questions concern the cost of doctors' services, the cost of hospital services, making arrangements to pay doctor bills and insurance. From the doctor's point of view, the discussion of fees was indicated to be "easy" by 42 per cent of the group, "relatively easy" by 35 per cent, "fairly difficult" by 15 per cent and "difficult" by only 8 per cent.

The questionnaires were distributed to 112 physicians—representing a cross section of the medical society membership — about a month after some 1,000 plaques had been distributed free by the local society.

To help practicing physicians create better relations with their patients, the American Medical Association is continuing to offer this plaque for one dollar, postpaid. Direct your request for the plaque to the Order Department, American Medical Association, 525 North Dearborn Street, Chicago 10, Illinois.

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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

You and Your Heart—A Signet Book, Revised and brought up to date, ($0.35. *The New American Library of World Literature, Inc., New York 22, N. Y.).* A book contributed to by five eminent specialists in the field of circulatory diseases designed to take fear out of the heart of the heart patient. It is worth recommending as such a tool to your patients.

Science and Human Behavior, by Burrhus Frederic Skinner, ($5.50. *MacMillan Company, New York 11, N. Y.).* Here a professor of psychology in the Harvard University makes a revolutionary and controversial approach to psychology. Discarding the theory of internal "will," Dr. Skinner contends that the way a man behaves in his daily affairs is the result of certain specifiable conditions. Once these have been discovered, we can actually predict his actions. His analysis carefully avoids an explanation in terms of impulses, wishes, emotions, character traits, attitudes, and the like. With this background, the author then examines man's social behavior as well as the current problems that bother us all.

Fundamentals of Disease, by Emmerich von Haam, M. D., 430 pages, 90 illustrations; ($4.75. *Springer Publishing Company, New York 10, N. Y.),* leads the nurse successfully to a clear understanding of disease processes. This fresh approach to pathology in the teaching of nurses was developed by the author in the carefully planned course of nursing instruction at Ohio State University.

Religion, Healing and Health, by James Dale Van Buskirk, M. D., ($2.50. *The Macmillan Co., New York 11, N. Y.).* Here a medical missionary restates for a Godless generation the principles of their "psychosomatic medicine" in terms of religion. He shows how faith can stabilize emotion and conquer fear, for what is there to fear if one becomes as a little child and walks with a hand in God's?

Medical TV Shows on Film. Catalog of four movies "tailor-made" for county medical society television use. Available without charge from TV Film Library, A. M. A., 535 N. Dearborn St., Chicago 10.

The Doctors Jacobi, by Rhoda Truax, ($3.50. *Little, Brown & Company, Boston 6, Mass.).* Mary Putnam Jacobi, daughter of George Palmer Putnam, the publicist, and Abraham Jacobi, a refugee from Europe, both physicians, changed the course of medicine in America and found for themselves a perfect partnership and marriage.

Neurosurgery—An Historical Sketch, by Gilbert Horrax, M. D., ($3.75. *Chas. C. Thomas Co., Springfield, Ill.).* A fascinating volume of the American Lecture Series on Neurosurgery, tracing this subject from prehistoric trephining to Horsley, Cushing, Frazier and Dandy.

Factbook on Medical Education. Pertinent questions and answers on progress of medical education in the United States . . . enrollments, financial support, faculty, and new medical schools. No charge. Department of Public Relations, A. M. A., 535 N. Dearborn St., Chicago 10.

Handbook of Differential Diagnosis, by Harold Thomas Hyman, M. D., ($6.75. *J. B. Lippincott Co., Philadelphia 5, Pa.).* Mindful of the exacting demands of modern diagnosis, the author of the large system of practice which he called **An Integrated Practice of Medicine,** has prepared an office manual for physicians in general practice and in the specialties making a broader interest in clinical medicine. It will also serve as an excellent bedside handbook for members of the resident staff. Its 1585 symptoms and signs make a working index to the 232 diseases of differential diagnosis—all in a pocket sized volume.

Problems of The Family, by Fowler V. Harper of the Yale Law School, ($9.00. *Bobbs-Merrill Co., Indianapolis 7, Indiana).* The contents of this book consist of cases and text notes on law readings from the literature of anthropology, sociology and psychiatry. It is put forth as an experiment in the integration of the various disciplines which deal with the family life. It certainly will broaden the grasp of anyone who comes in contact with these problems be he sociologist, priest, lawyer or physician.

A Laboratory Manual of Physiological Chemistry, by D. Wright Wilson, Benjamin Rush Professor of Physiological Chemistry in the University of Pennsylvania, ($3.25. 7th Edition. *Williams & Wilkins Co., Baltimore 2, Md.).* This book is intended to use as a teaching manual and not as a reference book.

The National Health Service in Great Britain, by James Stirling Ross, ($7.00. *Oxford University Press, New York 11, N. Y.).* This account of The National Health Service begins with the conditions which led up to it. The author insists that it is a British Service and should not be looked upon as something to ape, but in terms of the historical development of British Society. In this light one must stand disarmed, otherwise

your reviewer would be hopping mad if there were any thought that such a scheme would be good for us. Paupers must share poverty and do the best they can. The English are doing a noble job refusing to recognize that they are done in.

Collegiate Education for Nursing, by Margaret Bridgman, ($2.50. *Russell Sage Foundation, New York 22, N. Y.).* This book has been written with a full realization of the importance of providing nursing education at the college level to prepare sufficient potential candidates for certain specialized functions where such a background is needed. The author was appointed by the Sage Foundation to counsel with the Universities who asked for her. This volume comes then after visiting many campuses and a close range study of the situation.

Man and His Years—An account of the First National Conference on Aging, sponsored by the Federal Security Agency, ($1.75. *Health Publications Institute, Inc., Raleigh, N. C.).* A study of the problem as arranged by Oscar Ewing or subordinates. The book does contain much important information for all of us as we view the two great problems of what to do with our people and how to feed them.

Ballistocardiography, by William Dock, M. D., Harry Mandelbaum, M. D., and Robert A. Mandelbaum, M. D., ($9.50. *C. V. Mosby Co., St. Louis 3, Mo.),* presents the pertinent data for the application of the direct ballistocardiograph to clinical medicine.

Community Organization, by Sidney Dillick, Ph. D., ($4.00. *The Woman's Press, distributed by William Morrow & Co., New York, N. Y.).* This is said to be the first comprehensive history of neighborhood organization. An analysis of its present, past and future is made in the light of its past. The book is designed to give practical and concrete help to those citizens of good will who give so much of their time and money to serve on community boards and committees.

The Pharm-Assist Manual, Rewritten by A. E. Slesser, ($3.50. *C. V. Mosby Co., St. Louis, Mo.).* Formerly **Gray's Pharmaceutical Quiz Compend**, which has such a long and useful history.

Glaucoma—Pathology and Therapy, by Paul Weinstein, M. D., Translated by Julius Foldes, M. D., ($8.00. *C. V. Mosby Co., St. Louis 3, Mo.).*

Medical Progress—1953, Morris Fishbein, M. D., Editor, ($5.00. *Blakiston Co., Philadelphia 22, Pa.).* The editor has asked eminent authorities to contribute a summary of those fields in which he has sensed the most important advances during the year. An immense amount of well digested stuff is presented in 260 pages and in a volume that fits the hands and thus makes for comfortable reading.

Disability Insurance: 1952. A Review of Disability Laws—Operations 1942-52—The Legislative Picture as of May 1953. ($1.00. *The Research Council for Economic Security, 111 West Jackson Blvd., Chicago 4, Ill.).* A comprehensive presentation of the entire area of disability insurance under the state laws.

Successful Living, by Ernest Dichter, Ph. D., ($1.25. *Barnes & Noble, Inc., New York 3, N. Y.).* A consulting psychologist tells us how to attain happiness through an attempt to understand life.

The Sex Paradox—An Analytical Survey of Sex and the Law in the United States Today, by Isabel Drummond, ($5.00. *G. P. Putnam's Sons, New York 16, N. Y.).* A Philadelphia lawyer skilled in family matters and an author of several books on divorce and Corporate Resolutions has written a popular but authentic book on sex murders, homocides, juvenile delinquencies, rape, incest, assaults and perversions.

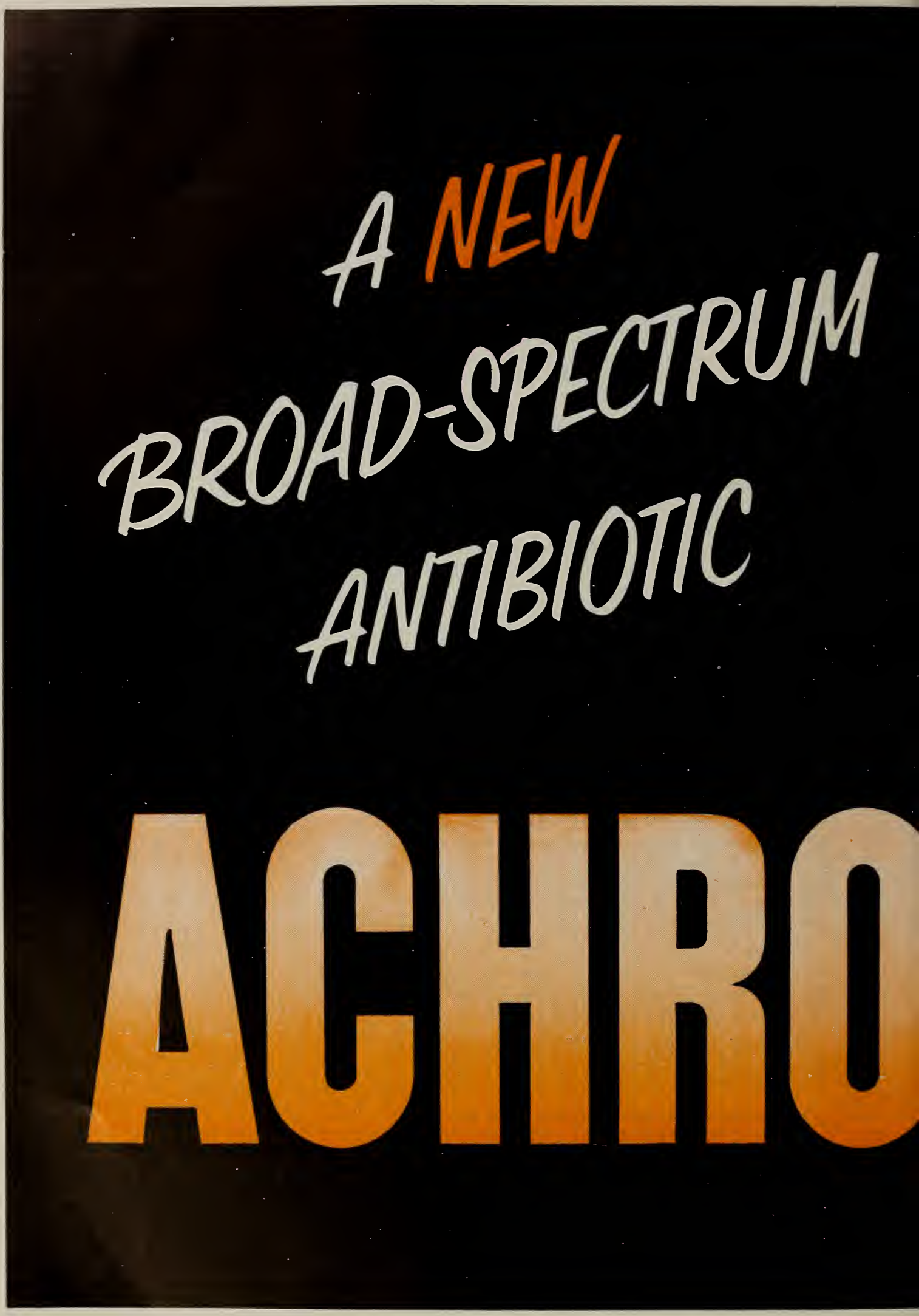
Health Saboteurs, by Robert William Davis, M. D., ($4.00. *Pageant Press, New York 36, N. Y.),* indicts the tonsil for everything from sinus trouble, crooked teeth and facial deformities, diabetes, nephritis, heart disease. The author urges their removal at any cost, even to control allergies. However, the vast majority of experienced allergists insist the tonsils be spared because of the resistance they offer. At any rate, here is an evangelist of a high order preaching the destruction of the tonsil.

Thoracic Surgery and Related Pathology, by Gustaf E. Lindskog, M. D., and Averill A. Liebow, M. D., ($15.00. *Appleton - Century - Crofts, Inc., New York 1, N. Y.).* This is a compilation of the knowledge available at this time with particular attention to those basic aspects of anatomy, physiology and pathology that are essential to an understanding of the subject. It is a contribution from Yale Medical School.

Peptic Ulcer, by Lucian A. Smith, M. D., and Andrew B. Rivers, M. D., of The Mayo Clinic, ($12.50. *Appleton - Century - Crofts, Inc., New York.).* A contribution to precise diagnosis and proper management of peptic ulcer without which failure ensues.

Surgical Pathology, by Lauren V. Ackerman, M. D., ($14.50. *C. V. Mosby Company, St. Louis 3, Mo.),* deals of course with the pathology of the living and so is an extension of general pathology and supplemental to them. It is an excellent text with superb illustrations. Every hospital library and laboratory should each have a copy.

Ways to Psychic Health, by Alphonse Maeder, ($3.50. *Charles Scribner's Sons, New York 17, N. Y.).* A distinguished Swiss psychotherapist interprets, through the presentation of case histories, the effective work that can be done with the mentally ill and presents a basis for spiritual and mental health.


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Vol. 50 February, 1954 No. 2

JONATHAN FORMAN, M. D., *Editor*

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The Value and Limitations of Endarterectomy In Chronic Arterial Occlusion

JOHN F. MACGREGOR, M. D., and FREDERICK GOETHE SMITH, M. D.

IN 1946 Jean Cid dos Santos[12] of Lisbon, Portugal, was successful in surgically restoring the patency of an artery occluded by an organized thrombus. The patient, a young woman suffering from severe ischemia of the right upper extremity, was found to have thrombosis of the subclavian artery due to the pressure of a cervical rib.

The artery was exposed, and through two incisions in the arterial wall, using a fine curet, dos Santos was able to remove the clot and the attached endothelium. The arterial incisions were sutured, and heparin was administered for four days. The artery remained patent and the ischemic symptoms were completely relieved.

This operation, which is termed endarterectomy, has proved to be a valuable addition to vascular surgery. Prior to the work of dos Santos, all attempts to remove organized arterial thrombi had been followed by recurrent thrombosis. In cases with major arterial occlusion chief dependence was placed upon improving the collateral blood flow by sympathectomy and at times the excision of the entire thrombosed segment of artery (arteriectomy). Where the primary arterial channel can be restored this is certainly the procedure of choice. In this paper we shall discuss present methods and indications for performance of this operation and describe our own observations in three cases which we have undertaken.

INDICATIONS FOR ENDARTERECTOMY

The procedure of endarterectomy owes its success to the fact that many cases of chronic arterial occlusion are segmental in nature. The principal causes of such obstructions are the following:

1. External pressure producing thrombosis (e. g. cervical rib, tumor, truss, trauma, and primary thrombosis of popliteal artery).
2. Arteriosclerosis.
3. Thrombosis of an aneurysm.
4. Embolus which has undergone organization.

It is important that the artery above and below the occlusion possess an adequate lumen. This fact must be determined accurately by preoperative arteriography. If the occlusion extends distally into the smaller branches, then very little benefit can be expected from disobliteration of the main artery. For example, endarterectomy in the superficial femoral and popliteal trunk will not greatly increase the flow of blood to the leg if the anterior and posterior tibial arteries are also blocked by atheroma and thrombosis. Some collaterals may be opened up, but re-thrombosis of the disobliterated segment is likely to occur.

By far the most frequent indication for this

Submitted September 21, 1953.

The Authors

● Dr. MacGregor, Owosso, Michigan, is a member of the surgical staff of Owosso Memorial Hospital; formerly, assistant in surgery, Frederick C. Smith Clinic, Marion, Ohio.

● Dr. Smith, Marion, is a member of the surgical staff, Marion City Hospital; assistant professor, department of surgery, the Ohio State University College of Medicine.

procedure occurs in arteriosclerotic disease, in which atheromatous deposits have caused ulceration of the intima or subintimal hemorrhage resulting in a localized thrombosis. This may occur in the distal aorta below the renal arteries resulting in the Leriche syndrome; it may involve the iliac or the femoral arteries; it is particularly

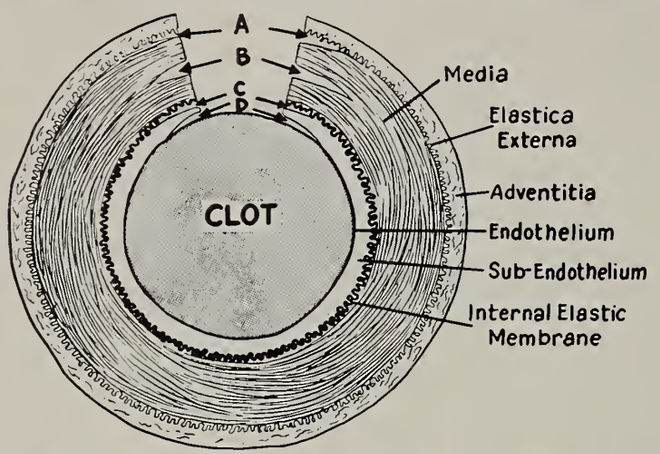


Fig. 1. Diagrammatic cross section of thrombosed artery showing the planes in which endarterectomy may be accomplished.

prone to occur in the superficial femoral artery in Hunter's canal and at the point where the artery passes through the loop of the adductor magnus tendon. It is less frequent in the upper extremity, where a local arteritis resulting from pressure of a cervical rib is more often the cause of segmental occlusion.

General principles of surgery apply to the proper selection of cases for endarterectomy. The aged patient, suffering from general arteriosclerosis with cerebral, cardiac and renal complications offers little hope in restorative surgery and is not likely to be a suitable subject for a rather long and tedious operation. Diabetes mellitus must be properly regulated prior to sugery. Cellulitis and spreading infection must be brought under control. Gangrene which is already well established and requires a major amputation cannot be benefited by endarterectomy, but early gangrene may sometimes be arrested and healing occur if the blood flow can be restored.

TECHNIQUE OF ENDARTERECTOMY

Endarterectomy consists of surgically stripping out the inner diseased coats of the artery together with the central clot, and then reconstructing the artery by suture. In embolism, in contrast to thrombosis, the clot lies free in the arterial lumen, and is easily extracted through an incision in the wall of the artery. In thrombosis the clot is attached to the endothelium and cannot be lifted out without leaving fragments of clot and ragged endothelium to initiate fresh thrombosis.

It is possible to establish a deeper plane of cleavage and lift out the clot encased in endothelium and more or less of the medial layer of the artery. The exact plane of cleavage depends upon the amount of degeneration which has taken place in the arterial wall; it may lie just outside the intima, it may be between the internal elastic membrane and muscle, it may split the muscle layer, or may separate the entire muscle layer from the external elastic membrane[1] (Fig. 1), The remaining arterial wall is quite smooth, has sufficient strength to be sutured, and will eventually acquire a new endothelial lining. Very soon after the inner coats of the artery have been stripped away a layer of leukocytes is deposited on the inner surface of the artery, which serves to retard clotting until the new endothelium develops.[11]

The occluded segment of artery as shown in the pre-operative arteriogram, and several centimeters proximal and distal to the occlusion are exposed by an appropriate incision.[1, 10]. The superficial aspect of the artery is cleared, large collateral branches are isolated and controlled with provisional ligatures of heavy silk. Rubber-covered bulldog clamps or Blalock clamps are then applied to the arterial trunk proximal and distal to the occlusion (Fig. 2).

An incision is made carefully into the exposed surface of the arterial wall in the occluded portion. This incision is deepened to the point where a natural cleavage plane develops between the live outer coats of the artery and the inner sequestrum of arterial wall, atheroma and clot. Following this cleavage plane the entire length of the affected segment of the artery is laid open with fine dissecting scissors. Using the scissors or a small blunt curet as a dissector the entire degenerated and occluded inner portion of the

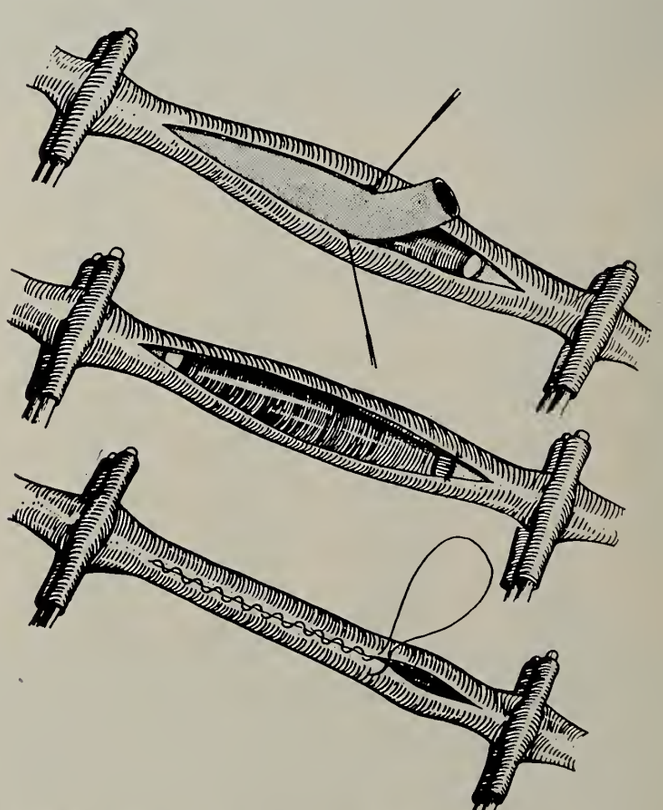


Fig. 2. Operation of endarterectomy showing the removal of the inner coats of the artery with the clot, and the reconstruction of the artery.

artery can be peeled away. Proximally and distally it is necessary to cut through the cuff of the endothelium and media. The clot and degenerated arterial wall can then be lifted out intact like a little sausage.[1]

The smooth inner surface of the artery bleeds slightly from the vasa vasorum, and any collaterals which have not been controlled will bleed quite actively. The artery is washed out with saline solution containing heparin, the clamps are loosened momentarily to wash out any debris and then tightened again. At the distal end the cuff of media and intima is cut across obliquely and attached to the wall of the artery with several fine silk mattress sutures placed through all of the coats and tied on the outside. This will prevent dissection of the blood between the coats.[2, 6] The axial incision in the artery is then closed with continuous 00000 arterial silk using either an over and over stitch, or a horizontal everting mattress suture.

When the incision has been closed saline containing heparin is injected into the sutured segment and the occluding clamps and provisional ligatures are removed. If bleeding from the suture line occurs it can be controlled by gauze pressure for several minutes, or an extra reinforcing suture can be inserted. Pulsatile flow of blood through the reconstructed artery can now be observed.

At the time the arterial suture has been completed the systemic administration of heparin should be started. It is in the immediate postoperative period that thrombosis is most likely to occur. There must be meticulous attention to hemostasis, observing the wound carefully after the first dose of heparin has been given intravenously in order to avoid serious postoperative hemorrhage.

There is no universal agreement as to the proper dose of heparin or the best route of administration. For immediate effect 50 mg. should be given intravenously. This is followed by a continuous slow drip of heparin in dextrose or saline solution sufficient to maintain the clotting time between 20 and 30 minutes by the Lee-White method. After heparin has been started and the surgeon is certain that further bleeding will not occur the wound is closed.

A soft Penrose drain extending to the plane of the artery but avoiding contact with the arterial suture line will give warning if serious bleeding should occur.[5] Heparin is given by continuous intravenous drip for 24 hours and after that time by intermittent intravenous injection, or in the form of repository heparin for 4 to 5 days.

CASE REPORTS

Case 1: Mr. ....., age 64 years, diabetic, complained of severe pain in the left calf after walking three blocks. Arteriography showed a localized occlusion of the left superficial femoral artery in the region of the lower portion of the femoral canal. There was an excellent collateral circulation, and good filling of the trunk distal to the occlusion.

On Dec. 15, 1952, a left superficial femoral endarterectomy was performed. The disobliterated segment measured 7 cm. in length. Heparin was used locally during surgery and a continuous intravenous infusion of heparin was started three hours after operation. After twenty-four hours the continuous intravenous heparin was discontinued and Depo®-Heparin was administered for eight days.

An arteriogram made three months after surgery showed the femoro-popliteal trunk patent and of good caliber. Six months after surgery the posterior tibial and dorsalis pedis pulses were present and of good volume, and claudication had been relieved entirely.

Case 2: Mr. ..... , age 59 years, suffered severe pain and weakness in the left calf after walking 300 yards. A femoral arteriogram showed occlusion of the superficial femoral artery commencing immediately below the origin of the profunda femoris artery.

On Jan. 10, 1953 left superficial femoral endarterectomy was performed. There was severe arteriosclerosis, with a narrow arterial lumen filled with thrombus extending through the entire superficial femoral artery into the upper part of the popliteal artery. The arterial disobliteration and reconstruction extended for a distance of 25 cms. Heparin was used locally during the operation and was given postoperatively by intravenous drip. Pulses failed to return and on the third postoperative day the popliteal artery was re-explored; it was found to be patent, and pulsating. Circulation to the foot and leg remained unchanged by the operation.

An arteriogram made two months postoperatively showed rethrombosis of the disobliterated segment. On March 28, 1953 a left lumbar sympathectomy was done with some improvement in collateral circulation to the foot.

Case 3: Mrs. ....., age 50 years, a diabetic, complained of cramping pain in both calves, worse on the left after walking one-half block. A left femoral arteriogram showed obstruction of the distal portion of the superficial femoral artery. There was a rich collateral circulation about the site.

On April 25, 1953, endarterectomy was carried out on the left femoro-popliteal trunk. The artery was cleared for a distance of 13 cms. Proximally a good lumen was obtained and many collaterals were opened up, but distally the popliteal artery was very small and the wall much thickened. It was impossible to re-establish a free flow of blood due to the severe disease present in the distal artery. Heparin was given postoperatively by continuous intravenous drip for 48 hours and Depo®-Heparin for three days longer.

No objective or subjective evidence of improvement in blood flow was obtained in this case. Left lumbar sympathectomy was performed on June 30, 1953, with improvement in skin temperature, but without relief of the claudication.

DISCUSSION

It is quite apparent that endarterectomy is limited in its field of successful application. In clinical practice it is arteriosclerosis which most often comes under consideration for this procedure. Arteriosclerosis is a generalized disease which affects the entire arterial system in various degrees. Most elderly patients, suffering from arteriosclerosis obliterans of the lower extrem-

ities, have far advanced obliteration of the arteries below the level of the popliteal. Disobliteration of these smaller arteries is impossible, and opening up of the femoro-popliteal trunk can add very little to the blood supply of such a limb. In these cases lumbar sympathectomy is frequently of value in improving the collateral blood flow.

There are, however, occasional patients, often in the younger age group in their forties or fifties, who can be greatly benefited by reconstructive arterial surgery. In these patients degenerative changes are far advanced in one segment of an artery, resulting in a localized occlusion. Muscular weakness and claudication incapacitate these patients, and gangrene may result if the thrombosis extends. The objective here should be the full restoration of function through reconstruction of the principal arterial channel.

The local complications following endarterectomy which may result in failure to restore blood flow are: (1) Thrombosis; (2) aneurysm; (3) hemorrhage. Of these, the most frequent is thrombosis of the disobliterated segment. Heparin is only partially successful in preventing thrombosis; a rapid flow of blood through a smooth channel of adequate size is also necessary to prevent clot formation. Failure in our second and third cases is attributed to thrombosis occurring in the long disobliterated segment. The higher the level of occlusion and the shorter the segment which is blocked, the greater will be the chance of successfully restoring the flow of blood.

Aneurysm formation has occasionally been described due to the weakening of the arterial wall produced by stripping away of the inner coats.[1] Hemorrhage is of greater importance and may be fatal.[1, 9, 13] The suture line in the diseased artery may give way with disastrous effect, particularly in the iliac arteries and the aorta. In elderly arteriosclerotic patients even a moderate hemorrhage may so depress the blood pressure as to initiate a coronary or cerebral thrombosis.

ALTERNATIVE TO ENDARTERECTOMY

As an alternative to endarterectomy the occluded segment of artery may be replaced with a preserved arterial homograft, or a fresh vein graft.[3, 4, 7, 8] Julian, de Takats, and Dye[7] state that they rarely perform endarterectomy except in isolated obstruction of the common iliac artery. They have used both fresh arterial homografts and autogenous grafts of the saphenous vein for the replacement of the femoro-popliteal trunk.

Vein grafts are not satisfactory for the replacement of the aorta or common iliac arteries. In the Leriche syndrome of insidious thrombosis of the aortic bifurcation, the occluded segment should be replaced with a suitable aortic homograft.[3, 7] If the occluded segment is to be replaced by a vascular graft great care must be taken not to destroy any important collateral branch. Endarterectomy has the advantage that all collaterals are preserved, and many which have been occluded are re-opened.

When endarterectomy is employed in localized arteriosclerotic occlusion of the common iliac or femoro-popliteal trunk, it is probably best to perform a lumbar sympathectomy before doing the arterial surgery. Endarterectomy then can follow immediately or within a few days. The patient is thus assured maximum benefit from surgery and spared an additional hospital stay for the sympathectomy if the reconstructive procedure fails.

SUMMARY

Endarterectomy affords a means of restoring the flow of blood through major arterial trunks occluded by localized thrombosis and arteriosclerosis. The operation consists of incising the artery, stripping out the clot and the inner diseased layers of the artery, and then reconstructing the arterial channel by suturing the remaining outer coats of the artery. As an alternative to endarterectomy the occluded segment may be replaced with an arterial homograft or autogenous vein graft. Reconstructive surgery of this kind is only successful if the occlusion is confined to a fairly short segment of a large artery, and there is minimal occlusion of the small distal arteries.

In three cases of endarterectomy for arteriosclerotic occlusion of the superficial femoral artery, we have been successful in fully restoring the blood flow and function in one case. In two cases the operation failed due to thrombosis of the disobliterated segment.

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Rheumatic Fever: New Hope for an Old Problem

CARL WEIHL, M. D.

THE EVENTS of the past 15 years have required a complete re-orientation of our research, therapeutic, and public health programs in childhood. Progress in prenatal and obstetric care has greatly lowered the infant mortality rate, and relegated congenital syphilis to the role of a clinical curiosity; the widespread use of immunizing vaccines and newer therapeutic agents has reduced morbidity and mortality from the common contagious illnesses to an all-time low ebb; and the use of chemotherapeutic and antibiotic agents, either before or after a diagnosis has been made, has pushed deaths from infections down near the bottom of the mortality tables.

This rearrangement of our thinking perforce focuses attention on the last of the major acquired, disabling diseases of childhood—poliomyelitis, accidents, and rheumatic fever.

Poliomyelitis, as a sequel to recent intensive clinical and laboratory studies, seems close to its ultimate solution, and relegation to a minor role along with the other acute contagious illnesses of childhood. Accidents, however, promise no easy and early solution. For those of us who are vitally interested in the public health problems of children, this is one of the major problems we face: accidents have rocketed to the first position as a cause of death in all age groups from 1 to 24 years.

Rheumatic fever is also a leading killer and disabler of school-age children. Although progress is being made, the fundamental cause of the disease process has not yet been determined. Only when this is achieved will we be able to transfer this illness to the group of "historic diseases" of childhood, such as rickets, scurvy, congenital syphilis, diphtheria and others. At present, it is one of the most important **soluble** medical problems remaining.

Until we reach this point of solution, however, it is our responsibility as individual physicians to recognize early the manifestations of this disease, to treat adequately the acute attack, to manage the convalescence with understanding, and, most important, to prevent the recurrences which account for the compounding of permanent cardiac damage that leads to ultimate disability.

CLINICAL DIAGNOSIS

Since practically all children ill with rheumatic fever are first seen in the home or office by the physician, it is important that the clinical manifestations of the disease be quite familiar to him in order to facilitate early diagnosis and treatment. A very practical approach to this problem is the grouping of the clinical signs of acute rheumatic fever into major and minor manifestations.[1] Since no one of these manifestations is entirely characteristic of rheumatic fever, the recognition of the disease syndrome will depend upon a combination of them, especially when they develop within one to three weeks after a streptococcal infection.

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MANIFESTATIONS

The major manifestations are five: (1) arthralgia and arthritis, (2) carditis, (3) chorea, (4) subcutaneous nodules and (5) recurrences of the disease (i.e., a verified history of previous attacks).

The minor manifestations include: (1) fever, (2) abdominal pain, (3) precordial pain, (4) rashes of various kinds, (5) epistaxis, (6) pulmonary changes and (7) certain laboratory findings.

It has been suggested[1] that we limit the diagnosis of acute rheumatic fever to patients who show:

(1) any combination of two or more of the major manifestations;
(2) the combination of at least one of the major manifestations and two minor manifestations;
(3) patients with rheumatic heart disease exhibiting minor manifestations, when no other cause for these manifestations can be found.

Great care must be exercised in making the diagnosis, since the serious implications of the disease have been well publicized to both professional and lay groups: hence too liberal diagnostic criteria may lead to unnecessary diagnoses, and the inevitable emotional and psychologic reorientation which the child with rheumatic fever must undergo. The danger of needlessly producing cardiac cripples in this manner is a real one which confronts us constantly.

Under the auspices of the Heart Association of Cincinnati we have recently established a clinic for adolescents with cardiac disease. We have been

From the Department of Pediatrics, College of Medicine, University of Cincinnati and The Children's Heart Association of Cincinnati.
Read at the meeting of the Ohio State Heart Association, April 23, 1953, Cincinnati, Ohio.

impressed with the integration of cardiac symptoms and disability into the personality structure of many adolescent children with little or no demonstrable cardiac disease. Since rheumatic fever affects most frequently children who are undergoing a period of marked emotional tension centering about their body structure and their needs to be independent, a diagnosis that threatens their organic integrity and deprives them of their maturing independence is one that should not be made lightly or too liberally.

LABORATORY DIAGNOSIS

Although much has been written in recent years about laboratory tests for rheumatic fever, we are still searching for a specific diagnostic procedure. The laboratory can provide many suggestive, confirmatory tests, but none that enables us to make a positive diagnosis in the absence of the foregoing combinations of major and minor clinical manifestations.

Generally, the tests we use can be divided into two groups: (1) those that are indicative of a recent acute streptococcal infection, which seems to precipitate most acute attacks of rheumatic fever, and (2) those nonspecific tests that are merely indicative of a disease process somewhere in the body.

The first group of tests employs titration of various antibodies against streptococcal antigens, the commonest of which is the antistreptolysin "O" titre. Since acute rheumatic fever is usually preceded by a streptococcal infection, the development of these antibodies is a part of the over-all disease process; and yet, any patient with a streptococcal infection will develop these antibodies in varying degree, while only a small number of these same patients will develop rheumatic fever. Similar rises in antibody titre are noted in patients with scarlet fever, acute nephritis, and streptococcal tonsillo-pharyngitis. Thus, these tests are specific only insofar as they provide evidence of a preceding streptococcal infection; they are not diagnostic of rheumatic fever.

The second group of tests are completely nonspecific, and merely represent changes in the blood that appear in many different diseases. They include the familiar leukocyte count and erythrocyte sedimentation rate, and the more recently proposed measurements of the non-specific antihyaluronidase titre, the C-reactive protein, serum mucoproteins, and others. These tests, of course, are considered significant only in the presence of other positive manifestations of rheumatic fever.[2]

The electrocardiogram also gives confirmatory evidence of the presence of acute carditis and is of value in following the progress of activity during the acute attack and immediate convalescent period. Electrocardiograms may be particularly useful in establishing a diagnosis in early and questionable cases, and in establishing the presence of activity in patients with rheumatic heart disease. In the recognized case of rheumatic heart disease the electrocardiogram provides aid in evaluating the strain on various cardiac chambers, and is, as always, a valuable tool for following drug therapy with digitalis and quinidine.

TREATMENT

The treatment of acute rheumatic fever is still entirely symptomatic, awaiting the uncovering of the specific cause of the disease. Recent interest has been stimulated by the introduction of ACTH and cortisone as therapeutic agents, but generally these drugs have not caused dramatic changes in the underlying disease process, though their use has occasionally been life-saving. Either drug will produce striking clinical improvement in the extracardiac manifestations of the disease, such as arthralgia, fever, tachycardia, anorexia, and anemia. The abnormal laboratory findings are often restored to normal within a few weeks.

The effects on the heart are more difficult to evaluate, but the great majority of clinical reports, borne out by our own experience, have indicated that ACTH and cortisone do not eliminate the underlying rheumatic activity, and that significant diminution in damage to cardiac structures during the acute attack has not been shown to occur. This factor will take the passage of more time to evaluate. Certainly, old, inactive morphologic changes of rheumatic heart disease are not affected by drug therapy.

PROPHYLACTIC TREATMENT

Of even greater importance than the therapeutic treatment of rheumatic fever is the newer body of knowledge which has been amassed concerning the prophylactic treatment of this illness. As many as 70 per cent of rheumatic patients may experience a recurrence of their disease.[3] Since the attacks are almost always preceded by acute streptococcal infections, and since the number and severity of these attacks are the principal factors affecting the severity of rheumatic heart disease, it is a public health problem of the first magnitude to prevent these recurrences.

In addition to the usual environmental and economic control measures used to reduce the transmission of streptococcal infections to these patients, the physician now has another tool of demonstrated value, and that is the daily, year-round administration of oral sulfonamide or penicillin to the rheumatic patient. While it is not feasible or desirable to use these agents on the general populace, it is mandatory that they be used in the patients who have had an initial attack of rheumatic fever, since they are much more susceptible than others to recurrences following subsequent streptococcal infection. In addition to daily prophylactic administration of penicillin or sulfonamide, it is of utmost importance to treat any streptococcal infection vigorously and early with penicillin and to administer prophylactic parenteral penicillin when

the rheumatic subject is undergoing procedures such as dental extraction or tonsillectomy.

An excellent and detailed outline of the prophylaxis of rheumatic fever has been issued recently by the American Heart Association.[4] In general, the prophylactic drug should be given the year round to rheumatic children, at least until they reach the age of 18 years. For older patients the therapy is given for at least five years after their last attack. At the present time, this program of prophylactic medication to prevent recurrences of rheumatic fever is the single most important measure which every physician and community rheumatic fever program can employ to alter the morbidity and disability rates in this illness.

OUTLOOK

The outlook for the patient with rheumatic fever is especially difficult to evaluate at the present time. An excellent survey of the long-term prognosis in rheumatic fever has been outlined recently by Bland and Jones.[3] Briefly, they found that of 1,000 rheumatic patients followed for a period of twenty years, 319 had no clinical signs of heart disease, 380 had rheumatic heart disease, and 301 had died. Of the 699 survivors, three out of four had little or no disability as a result of the disease.

In recent years there have been definite indications of a lessening of the severity of the disease and better control of it once it occurs. A number of different factors have contributed to the improved control of rheumatic fever. These factors include:

(1) **Preventive Programs**, employing sulfonamides and antibiotics to prevent recurrences;

(2) **Hormone Therapy**, with ACTH and cortisone, to treat acute attacks;

(3) **Prevention and Cure of Bacterial Endocarditis**, through the use of antibiotics, and

(4) **Cardiac Surgery** to ameliorate the morphologic changes of rheumatic heart disease.[3]

All of these factors utilized by individual physicians and community rheumatic fever control programs are significantly altering the natural history of rheumatic fever and rheumatic heart disease. The ultimate solution to the entire problem awaits determination of the cause of rheumatic fever—an answer that we can confidently expect will come in the not too distant future.

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KEEPING UP WITH MEDICINE

• IT IS MOST gratifying to those of us who have been harping on SOIL, FOOD, and HEALTH Relationships to the point where our friends are beginning to avoid us, to note that The Commonwealth Fund is now going to give priority to those applications for research grants of money to those problems which arise in the study of Man's relation to his environment. They, too, in the Annual Report agree that "sickness can seldom be laid to a single cause. More often it results from the inter-reaction of many aspects of a person's environment, both external and internal." Among these, factors affecting the nutritional state of the individual are by far the most important, may I add?

* * *

• THOSE OF US who enjoy "Gin and Tonic" as a beverage on a hot summer evening must be considerate in offering it to our friends who may be strangers to this tropical treat. Some persons have an idiosyncrasy for quinine and they may get in trouble with the small amounts in one of these drinks. It may produce ringing in the ears and even deafness.

* * *

• THE MOST notable advance in our understanding of the chemical role of vitamins has been the discovery that the various vitamins of the B group owe their biological activity to the fact that they can function as coenzymes in the living cell.

* * *

• WATER is the largest single constituent of all living matter, plant or animal. Water is fundamental in nutrition and has so been recognized from the earliest times. Human requirement for water is generally recognized to be one cubic centimeter for each calorie of food.

* * *

• DO WE get too much carbohydrate in our diet? This seems to be a possibility. About 20 per cent of our energy requirements should, most agree, come from carbohydrates. Just how many calories we need, however, has not been settled but the tendency seems to be to regard our present-day dietary allowances as too large.

* * *

• MILK FAT in the cow is derived by synthesis from carbohydrates in the mammary gland of the animal. Recent work using isotope-labeled materials shows that fatty acids and cholesterol can be synthesized from 2-carbon fragments in the mammary gland.

* * *

• THE RESEARCHERS now have the vitamins in the B complex up to No. 13. Vitamin B-13 is the name given to a factor in fish solubles and in distiller's dried solubles that will stimulate the growth of rats and chicks.—J. F.

A Case of Progressive Bilateral Bullous Emphysema Complicated by Pneumothorax

HOWARD H. ENGLANDER, M. D.

IN 1946 Price and Teplick[1] described a unique and peculiar type of emphysema to which they applied the name of "Progressive Bilateral Bullous Emphysema." They presented eight cases, and stated that only 13 other cases had been reported in the literature previously. No case has been reported that was complicated by pneumothorax. Therefore, it was felt that the following case, observed over a period of eight months, should be reported.

The Author

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CASE REPORT

The patient, a 45 year old negro male was admitted to St. Vincent Charity Hospital on October 20, 1948, in severe respiratory distress. He stated that an hour before admission, while lowering an awning, he suddenly became very short of breath and broke out in a cold sweat. There was no hemoptysis nor chest pain.

Later he revealed that he had suffered from slight shortness of breath for the last year; that he occasionally had a dry cough; that he found it difficult to throw off colds; and that he had become easily fatigued during the last year. Otherwise his past history and family history were negative.

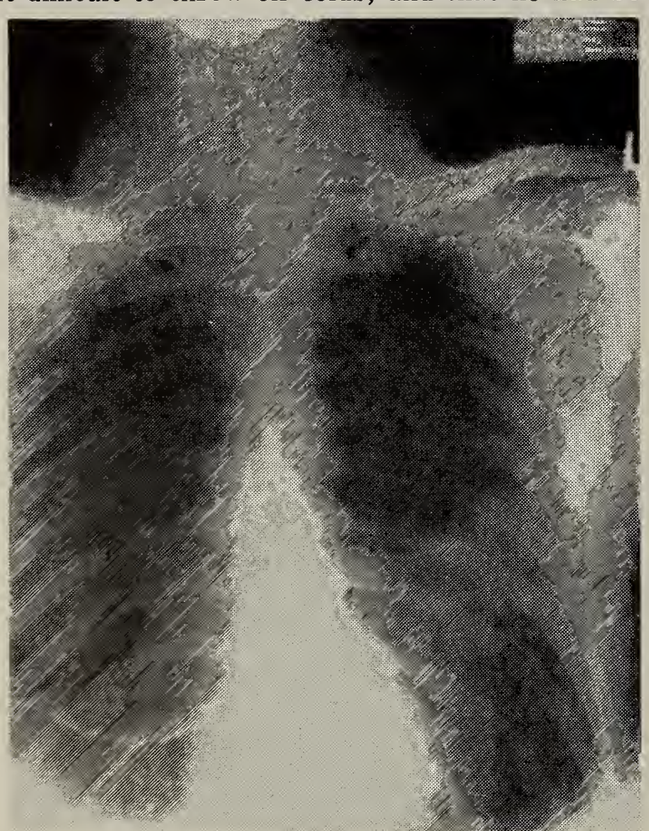


Figure 1

Physical examination revealed a temperature of 37.6°C., a pulse of 104, a blood pressure of 142/90, and a respiratory rate of 40. He appeared his stated age and well nourished. He was dyspnoeic and orthopnoeic, and cyanotic, and his skin was cold and moist. His jugular veins were distended. Examination of the chest revealed that the interspaces bulged on the left and that there was practically no respiratory movement on that side. The percussion note was tympanitic on the left and hyperresonant on the right. Breath sounds were diminished to absent over the left lung; where present, over the left upper chest, the expiratory phase of respiration was prolonged and wheezes could be heard. The remainder of the physical examination was negative.

Laboratory findings revealed a hemoglobin of 13.0 Gm., 5,000,000 red blood count, 15,000 white blood count, and a normal differential. Urine, blood sugar, blood urea nitrogen, and serologic tests for syphilis were within normal limits. The admission roentgenogram (Fig. 1), as interpreted by Dr. O'Malley of the radiology department of St. Vincent Charity Hospital, showed a "Pneumothorax, left chest, but apparently limited to the lower half of the left chest laterally. The upper half of either lung is the site of a huge thin walled lung cyst."

Hospital Course: The patient was treated with oxygen, carbon dioxide, morphine, and atropine. However, because his respiratory distress did not lessen under the foregoing regime and he seemed to be getting worse, one hour after his admission, his left chest was aspirated of about 1,000 cc. of air under increased pressure, and he was greatly relieved. At this time his chest roentgenogram (Fig. 2) showed considerable clearing of the pneumothorax. However, the next morning he was again in severe respiratory distress, and the needle was re-inserted, and he was put on constant drainage with air draining under water.

Radiographs on October 21st showed a considerable decrease in the pneumothorax but a pronounced subcutaneous emphysema. On October 22nd the needle was removed entirely. At this time he had subcutaneous emphysema of the chest wall, neck, and abdominal wall. He gradually became less dyspneic, and was discharged from the hospital on October 29, 1948.

Final roentgenogram on October 27th revealed, "Further re-expansion of pneumothorax on left. Upper portions of both lungs are the site of massive bullae or cysts. Some pleural changes at left costophrenic angle which probably represent a small amount of fluid. The subcutaneous emphysema is still present." Vital capacity on

From the department of medicine of St. Vincent Charity Hospital, Cleveland, Ohio.
Submitted September 5, 1953.

October 28, 1948 was 800 cc. or less than 24 per cent of normal.

Follow-Up: He was seen in the outpatient department on April 8 and June 24, 1949, and had no complaints either time. There was no weight loss, but he admitted, on questioning, that he became short of breath with slight exertion and that he was easily fatigued. No orthopnoea, cough, nor chest pain were present.

Physical examination on June 24, 1949, revealed a pulse of 76, a blood pressure of 126/80,

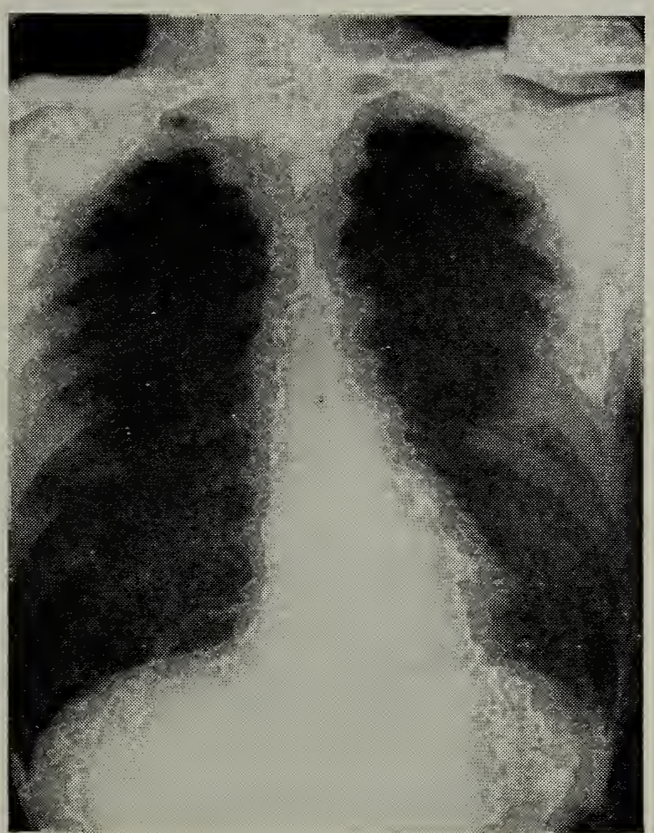


Figure 2

a temperature of 37.0 C., a respiratory rate of 22. Examination of the chest revealed an increased anteroposterior diameter with moderately diminished expansion bilaterally and symmetrically. The interspaces were full but did not bulge. The bases did not descend posteriorly. The percussion note was hyperresonant throughout. Breath sounds were normal except for a slight prolongation of the expiratory phase of respiration. There were no râles.

Except for somewhat distant heart sounds, the remainder of the examination was negative. Vital capacity at this time was 800cc. or 24 per cent of normal, the same amount as when he was discharged from the hospital. His hemoglobin was 14.5 Gm., red blood count was 4,350,000, and white blood count was 7,400. His chest plate (Fig. 3), the same day, showed no change in his pulmonary emphysema, but, of course, the subcutaneous emphysema and pleuritis had disappeared.

COMMENT

In common with Price and Teplick's[1] cases, mine was a male whose symptoms began in adulthood with dysponea and weakness. My patient, unlike theirs, showed little cough, no asthma-like attacks and no loss of weight; and, of course, my case was complicated by pneumothorax. Aside from the evidence of pneumothorax, roentgen findings were similar. Their terminology best seems to fit the circumstances, but it would appear that this is the same condition that Karol[2] designates as "Cystic Emphysema."

The latter condition begins early in life. The cysts gradually increase in size with the growth of the chest without encroaching on adjacent lung, and that is why it may be highly developed before discovery. However, Karol does not describe his cases in detail, and it is impossible to be certain whether my case fits his classification. In reviewing the literature, I discovered only one other case described that was complicated by pneumothorax,[3] but this was a unilateral emphysema.

ETIOLOGY UNKNOWN

The cause of this condition is unknown. According to Christie,[4] pulmonary emphysema may be classified into the following groups: (1) Chronic obstructive or hypertrophic emphysema; (2) senile or atrophic emphysema; (3) acute vesicular emphysema of the type seen in mountain climbers, which is readily reversible; (4) compensatory or localized emphysema, most commonly seen in uninvolved lung fields in patients with pneumonia or atelectasis.

Allison[5] would place this type of case in the obstructive category in Christie's classification, and Wiese[6] also stresses the obstructive origin of emphysema in which the modus operandi is the increased intra-alveolar pressure. However, Karol[2] points out the importance of inadequate blood supply, stating that, at post mortem, most emphysematous lungs are anemic and show pulmonary vascular atrophy and arteriosclerosis. In addition, 28 of his 100 cases had systemic

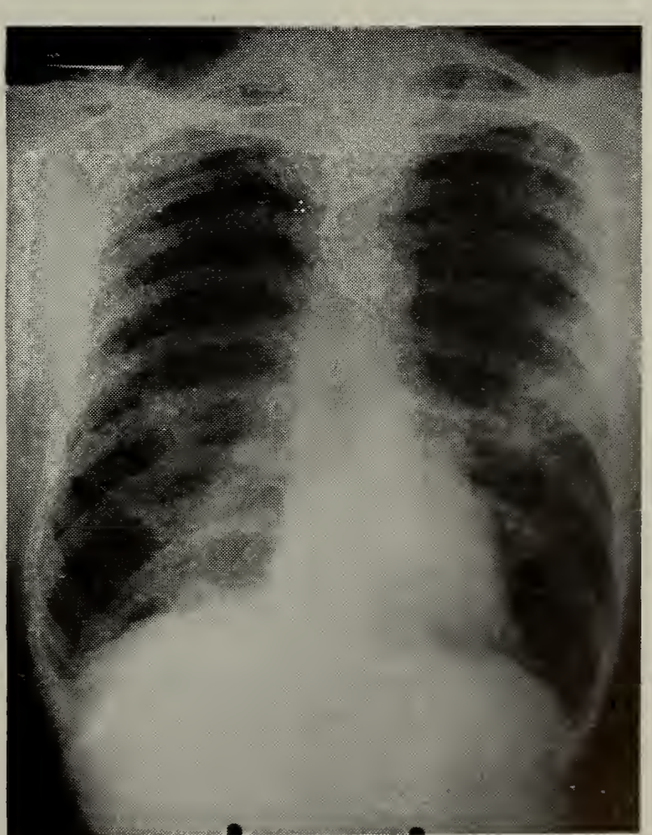


Figure 3

hypertension and arteriosclerosis, and 15 had syphilis which, he points out, attacks blood vessels; however, he also states that 23 of his cases had allergic bronchitis and asthma.

Certainly, in my case there is no definite evidence of an obstructive vascular etiology, and there is no certain evidence of any other associated lung diseases. Price and Teplick[1] have no explanation for their cases, and point out that it would be difficult to explain such cases on an obstructive basis; therefore, it would seem that the vascular explanation is more tenable.

The clinical features of dyspnoea, cough, wheezing, and loss of weight associated with physical signs of emphysema are not distinctive. Therefore, diagnosis is dependent on roentgenographic studies. The bullae apparently begin in the apices and extend downward, so that the chest plate shows bullae replacing normal lung markings in the upper lung fields with a patternless tracery of fine linear shadows. Confluence of some bullae and discreteness of others cause great irregularity of size and shape. The lower lung fields show interstitial fibrosis, and the thorax appears lengthened because of the depressed diaphragm.

In differential diagnosis, one can eliminate congenital cystic lung disease by the clearcut rounded cysts that are discernible and present elsewhere in the lung, and not only in the upper lung fields as in progressive bilateral bullous emphysema. A chronic bilateral pneumothorax should be differentiated easily by the long duration and the relative benignity of bullous emphysema, and finally special roentgenographic studies such as those taken in the knee-chest position would be distinctive. Also Wiese[6] differentiates bronchiectasis, tuberculous and abscess cavities by their locations and the nature of their walls.

PROGNOSIS

Prognosis is poor as the disease shows a slow progression over years with persistent or recurrent symptoms that gradually become more severe. Of the seven fatal cases analyzed by Price and Teplick,[1] death apparently resulted from the advance of the disease itself. Autopsies, where obtained, showed only incidental or resultant changes.

As to treatment, Price and Teplick state that there is no effective therapy. They recommend prohibition of smoking and strenuous labor, and the avoidance of respiratory infection. Certainly, when such cases are discovered early and are confined to a relatively small part of lung parenchyma, surgical removal should be attempted where feasible, as reported by Silversides,[8] and Naclerio and Langer.[9]

SUMMARY

1. A case of progressive bilateral bullous emphysema complicated by spontaneous pneumothorax is presented. Twenty-one cases have been presented in the literature previously.

2. The literature is reviewed, and it is pointed out that this is a distinct clinical entity. Diagnosis is made by roentgenographic studies; little is known about its etiology or treatment.

3. The condition is probably more common than the literature would indicate, as it apparently has been reported under several different names.

Acknowledgment is made to Dr. Monte Beck, the resident on Medicine, who cared for the patient in the hospital.

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Werner's Syndrome

In 1904 Otto Werner reported on the occurrence of "Cataracts in Connection with Scleroderma," an association which he had observed in four siblings. Thirty years later, Oppenheimer and Kugel reported the first 2 such cases in the American literature. They pointed out the essential clinical features of a condition which they termed Werner's syndrome.

Classic descriptions of this disease are available in these early reports as well as in two subsequent ones. In 1945 Thannhauser was able to collect but 25 definite cases from the world's literature. Histories of these cases, however, suggested that the disease had occurred in either its complete form or in "forme fruste" in other members of the same families.

In its fully developed form the disease presents the following characteristics: shortness of stature with characteristic habitus, canities, premature baldness, scleropoikeloderma, trophic ulcers of the legs, juvenile cataracts, hypogonadism, tendency to diabetes mellitus, calcification of the blood vessels, osteoporosis, metastatic calcification, characteristic changes in larynx, and tendency to occur in siblings.—Jere M. Bauer and Jerome W. Conn, Ann Arbor, Mich.: *Texas State J. M.*, 49:882, December, 1953.

Premature Synostosis of the Cranial Sutures: a Review*

FREDERIC N. SILVERMAN, M. D.

THE functional obliteration of the sutures of the cranial bones by means of bony continuity is called premature synostosis or craniosynostosis. Virchow, who reported the condition in 1851[1] coined the term "craniostenosis" to describe the constricting effect of cessation of bony growth on the cranial contents. The condition apparently was known prior to Virchow's report, but little attention was directed toward its study because it appeared to be an irremediable abnormality.

In fact, the early surgical enthusiasts were severely criticized by Jacobi[2] in 1894 in a review of 33 cases of surgical intervention in which results were confirmed by personal communications from the several surgeons. Jacobi's points were well taken, inasmuch as most of the operations were performed on individuals with microcephalic microcrania rather than craniosynostosis. Although Jacobi recognized that there might be some justification for the surgical treatment of patients with true premature synostosis of the cranial sutures, his opinion carried great weight and undoubtedly discouraged many subsequent operations, including some which would be indicated by present standards.

HISTORY OF THERAPEUTIC APPROACH

Up to 1924, surgical treatment of craniosynostosis was considered only palliative[3] and was used only after the complications or sequelae had appeared and after irreparable damage had occurred. In 1924, Faber[4] advocated revival of the Lane[5]-Lannelongue[6] surgical approach to the treatment of premature synostosis of the coronal sutures, and in 1927 he and Towne[7] reported a two year follow-up of a patient whose condition was diagnosed at birth, and who was operated upon at six months because of progressive deformity. Subsequently, Faber and Towne[8], Ingraham and associates[9] and others[10, 11, 12, 13] have reported an ever increasing series of patients surgically treated, with results which now make it imperative for everyone concerned with the care of infants to recognize this malformation at the earliest possible time.

As a consequence of a combination of clinical and roentgenographic observations, there have gradually emerged criteria for identifying those patients who may be expected to benefit from the surgical procedure and those who may not. Had Jacobi and his contemporaries had the benefit of roentgenographic technics, it is quite likely that the criteria would have been developed in their time and the treatment would have been established almost half a century earlier than it was.

This paper is concerned with the roentgen recognition of the usual varieties of premature synostosis and the criteria for identifying those patients in whom surgical intervention may be of benefit as well as those for whom surgical treatment has nothing to offer. Considerations of etiology are beyond the scope of this paper but we view the condition as a congenital malformation which can occur separately or in combination with other malformations. The incidence of craniosynostosis is probably greater than generally recognized becaused previous reluctance to accept these children for surgical treatment limited the number studied for diagnosis and reported.

Recently, McLaurin and Matson[13] reported that 120 patients have been operated upon at the neurosurgical service of the Boston Children's Medical Center, 36 of the children having been treated within the first six months of life. In the routine activities of our x-ray department,

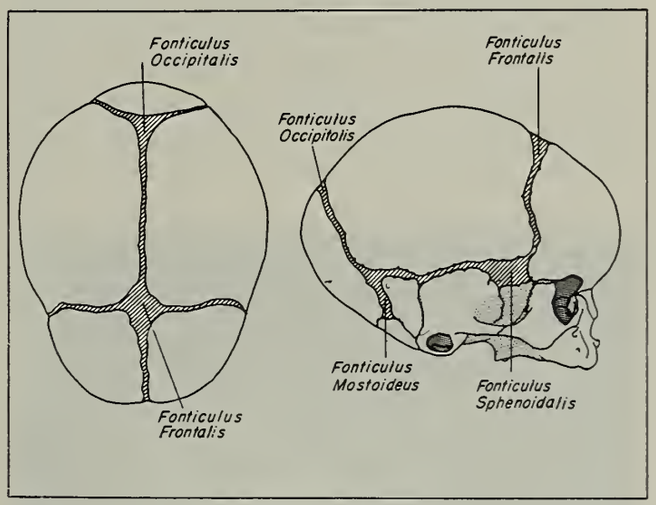


Fig. 1. Diagrammatic representation of normal cranial sutures and the fontanels. Sagittal suture—from FO to FF; Coronal suture—from FS through FF to opposite FS; Lambdoidal suture—FO to FM on each side; Squamosal suture—FM to FS. (Redrawn from Spalteholz).

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* Presented at the Annual Meeting of the Ohio State Medical Association, Cincinnati, Ohio, April 21-23, 1953.

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where no special effort has been made to seek out patients with this condition, approximately five patients are seen yearly. Within the last two years, several additional cases have been seen in consultation outside of the hospital. Craniosynostosis, therefore, is not a rare disease; its recognition and adequate treatment have been rare.

PATHOGENESIS OF CRANIAL DEFORMITY

The normal infant skull and major sutures are shown in figure 1. Although any or all of the sutures of the skull may be prematurely closed, the majority of patients suffer from premature closure of the sagittal suture or the coronal suture separately or in combination, and closure of all the sutures (generalized premature synostosis). The discussion therefore will be restricted to a consideration of the changes produced by each of these common types of craniosynostosis.

Three basic assumptions, for which there is ample support, must be kept in mind to understand abnormal growth of the cranial vault.

1. Growth of the vault is dependent upon growth of the cranial contents and particularly of the brain.
2. Growth occurs at the sutures in a direction perpendicular to the longitudinal axis of the suture.
3. Premature closure of one small segment of a suture is as effective in restricting growth as is involvement of the entire suture.

It is clear that if growth of the bony cranium is arrested at any one site, and the cranial contents continue to enlarge, compensatory growth must occur at other sites. One can practically predict the shape the skull will take if any single suture should close prematurely. By the same token, the prematurely synostosed suture may be inferred clinically prior to roentgen visualization by the shape of the skull. The demonstration of premature synostosis and the adaptive changes of the skull by roentgen technics is not only conclusive in identifying the condition but is of great value in determining how suitable the patient is for therapy.

Premature synostosis of the sagittal suture. This is by far the most common form of craniosynostosis, occurring in about 50 per cent of the cases recorded. This suture is responsible for lateral growth of the vault; loss of its function through premature synostosis will prevent the skull from growing in width. If the cranial contents are to continue to grow, compensatory changes must take place in those sutures which still remain open. These include the coronal suture, the lambdoidal suture and the squamosal suture. The skull, as a consequence, can grow in the anteroposterior diameter and in the vertical diameter. The cranial vault may be more narrow than the face. It is unusually long when seen from the side and tends to be high as well. Figure 2 illustrates the cranial configuration in a child with premature synostosis of the sagittal suture and figure 3 illustrates the typical roentgen features.

Throughout childhood, at least, the sutures are generally clearly defined radiologically. In the anteroposterior projection in figure 3 not only is the radiolucent line of the suture invisible, but there is actually a ridge of bone in the region of the suture. This ridge frequently can be palpated

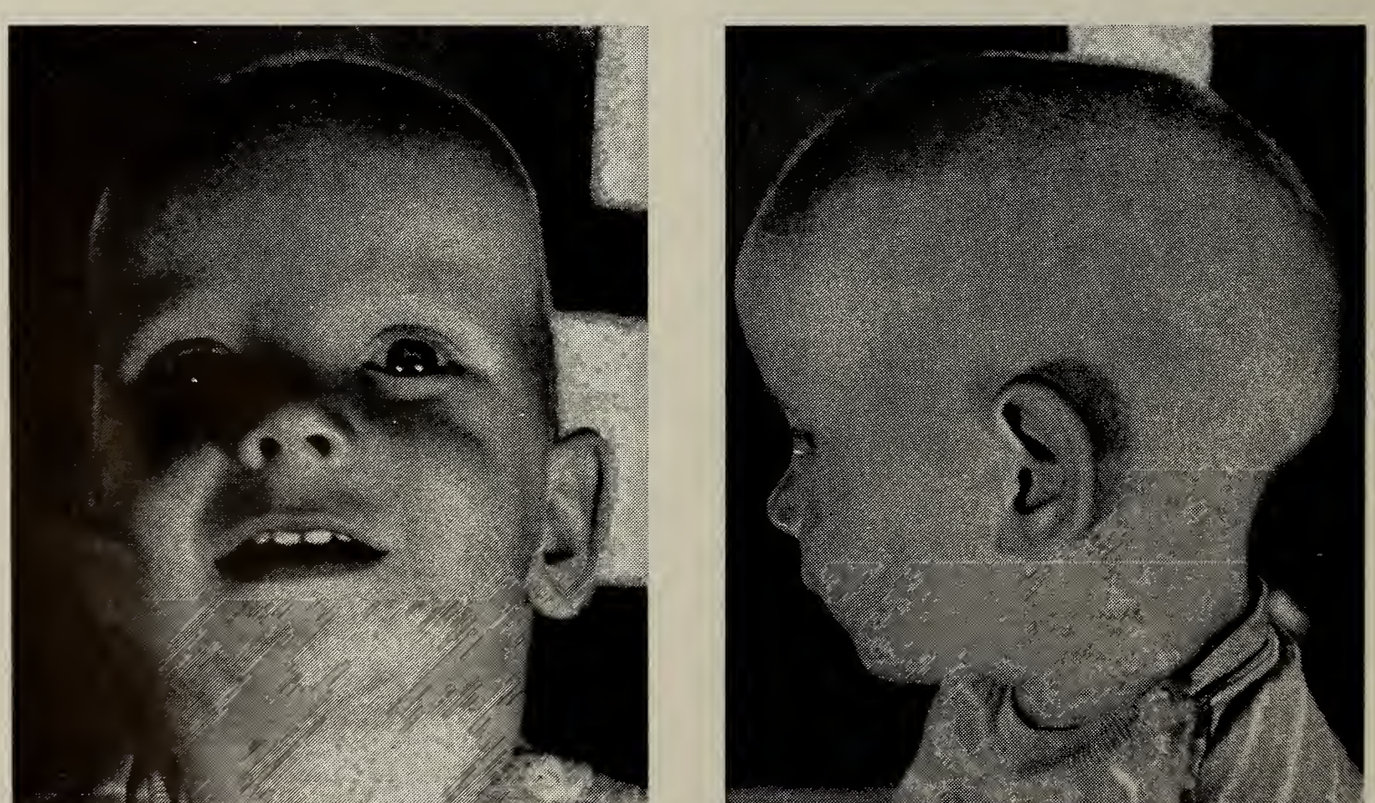
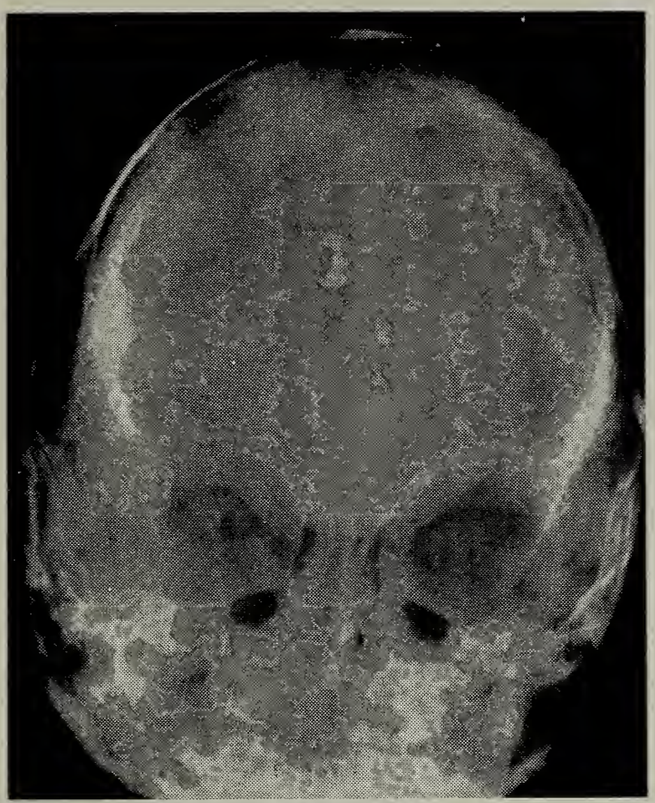


Fig. 2. Premature synostosis of sagittal suture (clinical features). Note high, narrow and elongated cranial vault.



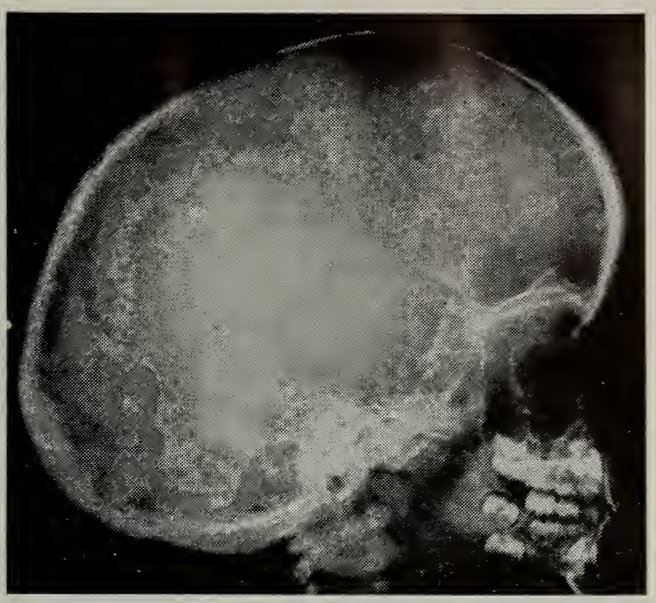


Fig. 3. (Left and above.) Premature synostosis of sagittal suture (roentgen features). In bright light, original film shows ridge of bone at site of prematurely closed sagittal suture.

clinically through the scalp. If there is any limitation of compensatory growth of other sutures, increased intracranial pressure can develop, and is manifested roentgenographically by heavy digital markings. As a general rule heavy digital markings are found only in cases which have been permitted to continue untreated for several years or in special instances which will be described later.

Premature closure of the coronal suture. The occurrence of this condition is second in frequency, particularly if the strictly unilateral cases are included. Unfortunately, there is a high incidence of associated congenital anomalies in this group of patients, syndactyly in particular. Deformities of the base of the skull resulting from the abnormal growth of the vault produce more serious disfigurement and constitute a serious threat to vision. Moreover, among the associated anomalies, gross defects of the brain may be present which may vitiate the results to be expected from the surgical procedure.

If the coronal suture is prematurely synostosed, it is obvious that the skull cannot grow to any great degree in the anteroposterior diameter. Compensatory growth must take place upward and laterally and such is the case. Figure 4 shows not only the high wide skull resulting from premature synostosis of the coronal sutures but also indicates the deformity of the orbits which makes them more shallow than normal, produces exophthalmus and causes pressure of the taut optic nerves against bony prominences.

Unilateral fusion of the coronal suture (plagiocephaly) produces ipsilateral flattening of the anterior portion of the skull and distortion of the ipsilateral orbit. Disfiguring asymmetry of the skull may develop if this condition is untreated and neurological manifestations may have a definite relationship to the abnormality in growth in this local region of the skull. Figure 5 illustrates the roentgen manifestations of premature synostosis of one coronal suture. The deformity of the orbit on the affected side is comparable to the bilateral deformity in figure 4.

Combined premature synostosis of sagittal and coronal sutures. This is less common than the other types herein described but fairly characteristic clinically and roentgenographically. It carries the same stigma of associated anomalies as does premature synostosis of the coronal sutures alone. The only sutures which are available for compensatory growth are the lamboidal and the squamosal. (See Fig. 1.) Growth, therefore, is limited almost exclusively to the vertical diameter of the skull. The head is narrow (sagittal growth defect) and short anteroposteriorly (coronal growth defect), but is disproportionately high (Fig. 6). In such cases, clinical diagnosis is often more revealing than roentgen diagnosis.

The lambdoidal and the squamosal sutures are seldom involved separately. The metopic suture is occasionally involved as a single abnormality. This results in a somewhat pointed forehead resembling the prow of a boat but is of little consequence since the metopic suture normally fuses early in life and contributes very little to the total overall growth of the skull.

Premature synostosis of all the cranial sutures —generalized craniosynostosis. These are the least common of the several types of premature synostosis but of equal importance from the standpoint of early surgery. Moreover, they provide significant clues to assist in the evaluation of

children with less extensive disturbance of the cranial sutures.

If all the cranial sutures are prematurely fused, a true condition of microcrania exists. The brain, which has its greatest increase in size during the first year of life (85 per cent increase in weight in the first six months and 135 per cent increase in weight in the first year), is completely hemmed in on all sides and even compensatory growth into an abnormal shape is not permitted. The intracranial pressure rises rapidly as the normal processes of cerebral growth attempt to proceed in the rigid bony case, and adverse effects upon the brain can be expected early.

Clinically, these children with symmetrically small heads are indistinguishable *in appearance* from microcephalic microcrania. If the condition occurs very early in life, the performance of the two groups of children may not be significantly different. Roentgen examination of the skull, however, is practically conclusive in differentiating the two conditions; one in which a potentially normal brain is restricted by a rigid brain case. and the other in which failure of development of a defective brain is reflected in failure of growth of its container.

In the former case, signs of increased intracranial pressure appear early as markedly exaggerated digital markings. (Fig. 7.) The bones are thinned; craniolacuna-like areas of softening have been described. The ratio of the size of the facial area in lateral projection to the size of the cranial vault is not dissimilar from that in the primary microcephalics and is appreciably increased in comparison with normal. In microcephaly, however, careful inspection may demonstrate that the sutures are open notwithstanding this gross cranio-facial disproportion.

If the sutures are prematurely closed as a result of the lack of stimulus from within, signs of increased intracranial pressure do not appear. Instead the bones of the vault are grossly thickened and pneumatization of the temporal bone is greatly exaggerated. These changes occur in a fashion which calls to mind the dictum in the physical sciences that "nature abhors a vacuum." There appears to be some delicate balance between the pressure of the growing brain on the one hand and the tendency of the mucosa of the upper naso-pharyngeal passages to invade the bone from without the cranial cavity.

When growth of the brain is deficient the pneumatization appears to be exaggerated. When growth of the brain is exaggerated (as in hydrocephalus) pneumatization appears to be retarded. This is particularly well shown in hemiatrophy or hemihypoplasia of the brain, in which case the involved side of the cranial cavity is smaller than the opposite side and this smallness is associated not only with a decrease in volume but with an

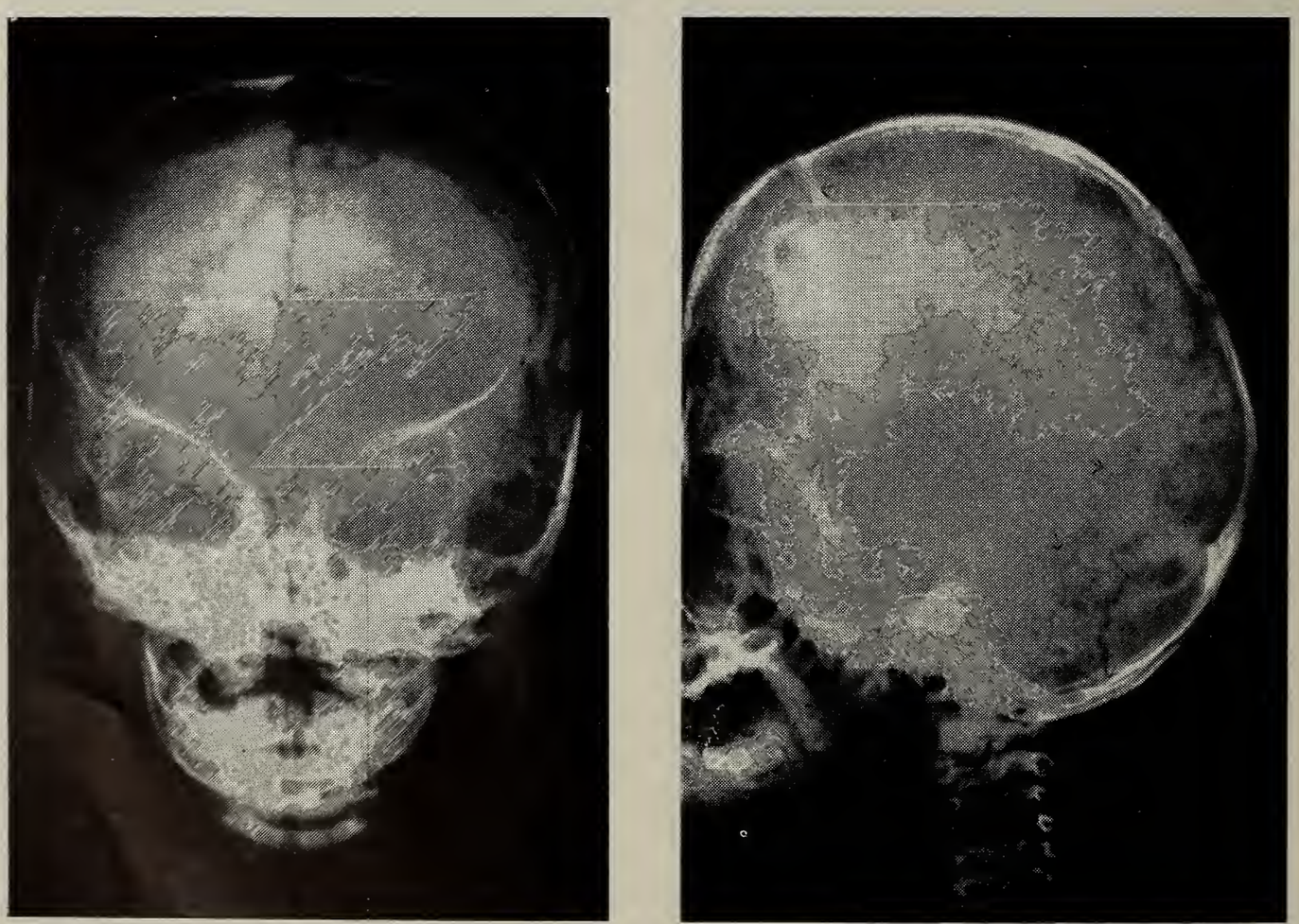


Fig. 4. Premature synostosis of both coronal sutures. The vault is high, wide and shortened anteroposteriorly. The metopic suture is prominent in the P-A projection. Note distortion of orbital roofs. (From Babies Hospital in New York City.)

increase in thickness of the bones on the involved side and an exaggerated pneumatization of the ipsilateral temporal bone. Infection and hereditary factors which modify the pneumatization of the temporal bone cannot be disregarded in evaluating this sign.

The absence of signs of increased intracranial pressure, the presence of exaggerated pneumatization in the mastoid temporal bones in a child with a small head, with or without premature closure of the sutures, points immediately to a defect in cerebral development, which no amount of surgical intervention can improve. Figure 8 is an illustration of a child with microcephalic microcrania demonstrating these features.

IRREGULAR SEQUENCE OF CLOSURE

The "pure" types of premature synostosis of cranial sutures described above are somewhat confused by the various combinations possible and particularly by varying sequences in which the several sutures involved begin their fusion. A child who begins to have fusion in the sagittal suture initially, may show first a long narrow head; with subsequent involvement of the coronal sutures, the skull may cease its anteroposterior elongation and grow more in the vertical direction. The net result is a bizarre deformity of the cranial vault which may defy analysis of sutures involved if one thinks only in terms of individual suture involvement or simultaneous suture involvement.

Of practical importance is the fact that the child who has had premature synostosis of one cranial suture should be observed closely for the subsequent development of premature synostosis of other sutures. This is particularly important in the plagiocephalic type of skull (premature synostosis of one coronal suture) where the tendency for later involvement of the opposite coronal suture is especially great.

The appreciation that progressive distortion of the cranial vault in association with premature synostosis of the sutures indicates that the brain underneath is growing, permits the identification of those children with incomplete synostosis who may benefit from surgery. The roentgen recognition of increased intracranial pressure as well as distortion of osseous structures also serves to identify those children with potentially normal brains. On the other hand, the recognition of nature's attempts to compensate for inadequate pressure stimulus on the internal aspect of the cranial cavity by over-development of the "pressure" factors on the external aspect of the cranial cavity serves to point out those children whose problem is not one of surgical therapy.

TREATMENT

Since this paper is primarily concerned with the diagnosis of premature synostosis of the cranial sutures, only a brief discussion of the therapy can be undertaken. Reference should be made to those papers[8, 9, 10, 11, 12, 13] in which the technics of therapy are considered in great detail. Suffice it to say that most authors now agree that the procedure of choice is the creation of artificial sutures which replace or parallel the normal sutures and which will permit expansion of the skull in the direction in which the synostosed suture restricts

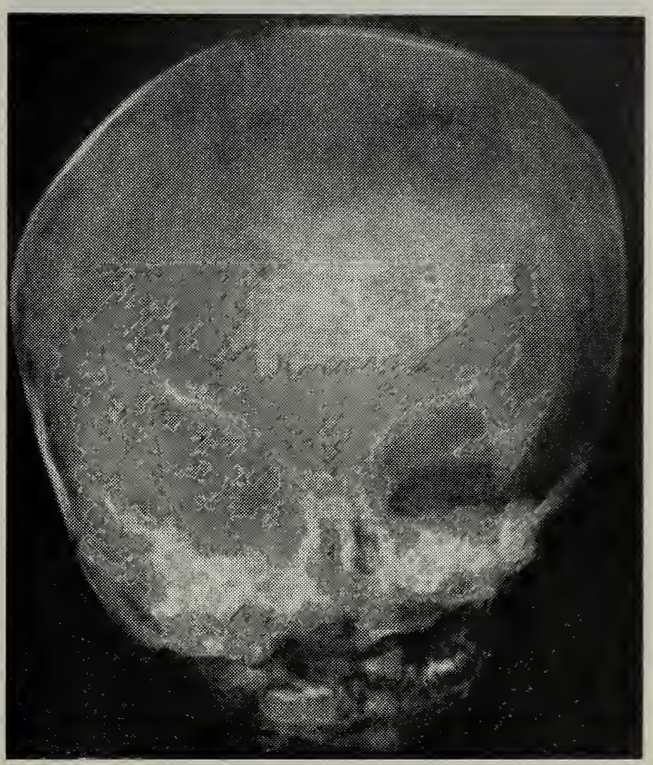


Fig. 5. Premature synostosis of right limb of coronal suture. (Plagiocephaly). The left orbit is normal; compare distortion of roof of right orbit with bilateral distortion in Figure 4.

growth. Prompt improvement in cranial shape and measurements and widening of the artificial sutures clearly demonstrate the need for space by the brain.

One of the early objections to surgical intervention was the observation that even wide areas produced by removal of strips of bone bridged over within four months to a year after surgery, and that therefore the amount of expansion of the cranial vault was extremely limited unless multiple procedures were to be undertaken. It has been found that shielding the cut edges of the bone by thin strips of polyethylene film will prevent bony union and thereby permit unrestricted expansion of the cranium to conform with the growth of the underlying brain.[14]

The value of surgical treatment is indicated by the fact that children operated upon within one year of the onset of the condition show a greatly lessened incidence of mental retardation in comparison with those children who are operated upon later. Treatment during the first six months of life is advocated and is feasible since as many as 80 percent of the patients may have their deformity noted during this period.

In a review of 36 cases treated during the first



Fig. 6. Premature synostosis of coronal AND sagittal sutures (clinical features). Only vertical growth can take place. Note the shallow orbits and proptosis. Malformations of the extremities are present in this case.

six months of life[13] there was no apparent mental retardation in follow-up periods up to six years in 19 children with premature synostosis of the sagittal suture. Two patients of ten with premature synostosis of the coronal suture were retarded, and these were considered retarded prior to surgery. Though still below average, the two infants were progressing in mental development at the time of the report. Only one patient of five with multiple suture involvement showed retardation and this patient also showed retardation prior to the surgery. All the patients with retardation have shown progressive development although they are still retarded in comparison with normal.

It should be noted that not all children with premature synostosis of the sutures will be mentally retarded if they are not operated upon. However, it is not possible by present technics to determine which children will be unaffected by their deformity.

The risks of surgical intervention in proper hands are relatively small compared to the risks of progressive mental deterioration or blindness. Not to be overlooked, too, is the psychological effect of cranial and facial deformities. It would therefore seem the path of wisdom to give all children with the deformity the benefit of doubt when there is any reason to believe that a growth potential exists in the brain. The roentgen examination is of extreme importance in this regard. We can only echo the words of the distraught mother who first suggested surgical intervention for her microcranial child when she approached Dr. Lane in 1888 with the question "Can you unlock my poor child's brain and let it grow?"[5]

SUMMARY

Premature synostosis of the cranial sutures may occur in the presence of a brain with normal growth potential or in association with developmental defect of the brain. When all the sutures are not involved, progressive distortion of the skull indicates a growing brain; when all the sutures are involved, roentgenograms show evidence of increased intracranial pressure if the brain is growing. In both instances the abnormal sutures are generally identified by roentgen examination.

If the primary defect is in the brain, roentgen examination of the small head may demonstrate normal sutures. When the sutures are closed, there are no signs of increased intracranial pressure, the bones may be thicker than normal and pneumatization of the temporal bones may be exaggerated.

Surgical creation of new sutures in sites where normal skull growth is impeded, permits optimal development of growing brains. Best results in terms of mentality and cosmetic results are ob-

tained with surgery during the first six months of life. Previous poor results from surgical treatment of microcrania and mental retardation probably arose from improper selection of cases to include primary developmental defects of the brain. The clinical and roentgenographic signs described and illustrated allow proper selection of patients for the procedure.

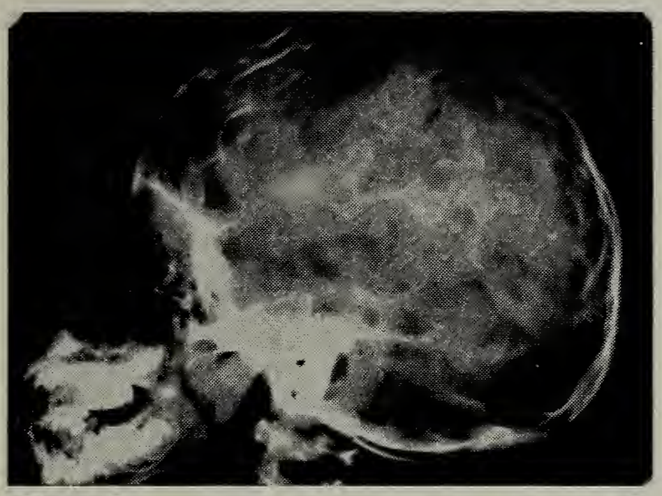


Fig. 7. Premature synostosis of ALL sutures. The facial area is large in relation to the vault and microcrania is present. Pressure of the growing brain is reflected in the exaggerated digital markings.



Fig. 8. Microcrania due to microcephaly. The facial area is large in relation to the vault, but there are no exaggerated digital markings, the bones of the vault are thick, and pneumatization of the temporal bone is very extensive. Compare with Figure 7.

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Psittacosis in Georgia

Parakeets have been enjoying a widespread and increasing popularity as household pets since 1951, when changes in the Interstate Quarantine Regulations removed all Federal restrictions on shipments of psittacine birds from psittacosis-free areas in the United States.

No epidemics of psittacosis, the virus infection transmitted to man by these birds, have since been reported, and the public has assumed that this disease will rarely be encountered, provided the birds have not been brought illegally into this country.

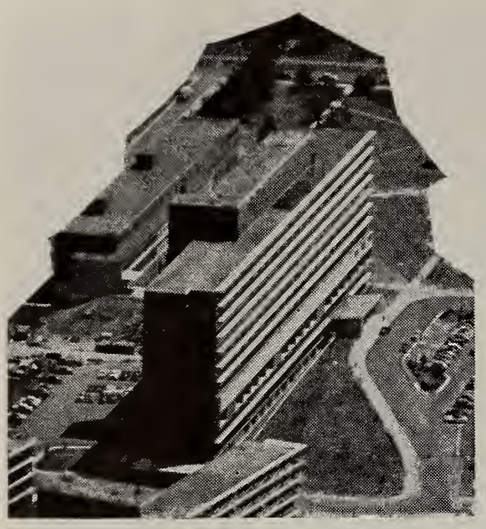
Sporadic cases and small outbreaks are being reported throughout the United States, however, and it is probable that the psittacine origin of many cases of "virus pneumonia" or "primary atypical pneumonia of unknown etiology" remains unsuspected.

The purpose of this report is to call to the attention of the physicians of our state that cases of psittacosis are being seen in Georgia. They are urged to report instances of this infection, so that a more accurate appraisal of its incidence, and thereby, its importance or lack of importance as a public health problem, can be made.

The problem is not limited to parakeets, since a wide variety of birds, including parrots, canaries, pigeons, doves, rice birds, finches, sparrows, pheasants, gulls, turkeys, chickens, and ducks are susceptible to infection with psittacosis and related viruses.

In man the infections appear more severe when acquired from members of the parrot family. The term "psittacosis" has been used to designate those infections of man and birds originating in the parrot family. The latter includes, besides parrots and parakeets, Amazons, Mexican double heads, African grays, cockatoos, lovebirds, lories, and lorikeets.

The term "ornithosis" is often used to refer to avian infections of non-psittacine origin. At times, however, both terms have been used interchangeably to designate the entire group of avian viral infection. — Charles M. Silverstein, M. D., Atlanta: *J. M. A. Georgia*, 42:341, July, 1953.



A Case Record

From The University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Edward Goodsitt, M. D., President

Presented by P. B. Hardymon, M. D., and E. von Haam, M. D. Edited by Dr. von Haam

PRESENTATION OF CASE

THE patient was a 15 year old white male who was admitted complaining of a slowly growing, painless mass in the left side of the abdomen which had been present for six to eight months. Eight months before hospitalization he had received a blow in the abdomen during a boxing match. He felt nauseated following the trauma and missed school for four days. He had been asymptomatic since that time. Five days prior to admission the patient underwent a routine physical examination in order to play basketball. The examining physician found a mass in the abdomen and referred the patient to the hospital for further examination.

Physical Examination: On admission to the hospital the blood pressure was 120/75, pulse 80, respirations 24, temperature 99°. The heart sounds were distant and weak. The lungs were clear to percussion and auscultation. On examination of the abdomen a large, fixed, firm, nontender mass was found in the left epigastrium. Rectal examination was negative.

Laboratory Data: The admission red blood count was 6.4 million, hemoglobin 16.4 Gm., white blood count 16,000 with 84 per cent neutrophils, 13 per cent lymphocytes, 2 per cent eosinophils, 1 per cent monocytes. Urinalysis showed 1 to 2 red blood cells and an occasional white blood cell. Blood chemistry: blood urea nitrogen 11.5 mg.; sugar 79 mg.; prothrombin 86 per cent; cephalin flocculation, trace; total protein 6.45 Gm.; serum amylase 45.5 units; calcium 13 mg. Lipase was 0.42 units. Urinary excretion of 17-ketosteroids was approximately 150 mg. in 24 hours, while the excretion of 11-oxysteroids was 2.83 mg. in 24 hours. Fluid removed from the abdominal mass at operation showed 7.5 mg. of calcium.

X-ray Studies: Radiographs of the abdomen showed a 24 cm. fairly well circumscribed mass having a peripheral rim of calcification and flocculent mottled calcifications within the mass. It was located within the upper and middle quadrants of the abdomen. A chest plate was negative. An intravenous pyelogram showed dilatation of the left calyx and pelvis and some widening of the ureter. On the lateral film the left kidney appeared displaced somewhat posteriorly and compression of the ureters was evident from the mass. The mass appeared separate from the kidney parenchyma. Upper gastro-intestinal series and barium enema showed only pressure effect on the stomach and colon from the mass. The opinion of the radiologist was that we were dealing with a pancreatic cyst with calcifications. Anteroposterior radiograph of the hands for bone age showed epiphyseal union of the phalanges, radius and ulna corresponding to a maturation age of at least 18 and nearly 19 years.

Hospital Course: A diagnosis of pseudocyst of the pancreas was made. At laparotomy a very vascular tumor was found in the abdomen which did not seem to be attached to the pancreas but to the posterior abdominal wall. The mass contained much cheesy yellow material. Marsupialization was first attempted but when oozing persisted, removal of the cystic tumor was done. However, the patient continued to bleed and in spite of 42 pints of blood given him in the operating room expired shortly after the laparotomy had been closed.

CLINICAL DISCUSSION

DR. P. B. HARDYMON: This is a very unfortunate case. This young man was admitted complaining of the presence of a slowly growing painless mass in the left side of the abdomen of approximately six to eight months' duration.

He also gave a history of having been struck in the abdomen while boxing with a friend approximately seven to eight months prior to this time. He was nauseated, vomited, stayed in bed and missed school for four days. There was an interval of approximately one month between this accident and the beginning of the growth in the left side of the abdomen.

On the basis of this history we established a diagnosis of traumatic cyst of the pancreas, fitting the remainder of the findings as well as possible into the picture. When a blunt force as a fist strikes the abdominal wall it impinges the deep-seated pancreas against the vertebral column, causing a contusion with subcapsular hemorrhage and possible rupture of the capsule. The release of pancreatic enzymes into the peritoneal cavity produces then a fat necrosis with liquefaction and the formation of a so-called traumatic cyst of the pancreas. Such sequence of events is not uncommon although the pancreas is otherwise a well protected organ.

THE EXAMINATION

The examination of the abdomen revealed a large firm mass in the left epigastrium which extended to the left hypochondriac area and the rim of the ilium on the left side. It actually measured 25 to 26 cm. across and was quite a tremendous and impressive tumor which was not particularly tender even after repeated examinations.

The x-ray findings confirmed the physical examination and showed a fairly well circumscribed mass measuring 24 cm. in diameter which was partly calcified pancreatic cyst. The epiphyseal union of the phalanges, radius and ulna which corresponded to a bone age of at least 18 and nearly 19 years does not impress me too much in a 15 year old boy who is well-developed and muscular. We know of course that certain adrenal tumors produce hormones which lead to precocious maturity and the patient's 17-ketosteroid excretion was increased tenfold above the normal, but without the presence of virilism or hypertension we paid little attention to those findings.

The fact that the patient had no trace of an anemia ruled out, to my opinion, any kidney tumor, which always bleeds a great deal and soon causes a secondary anemia. The other laboratory tests were all within normal limits including the serum amylase.

Our final diagnosis was a traumatic pseudocyst of the pancreas and surgical removal of the cyst was decided upon. Following laparotomy a mass was found in the abdomen which was attached to the posterior wall of the abdomen and was found to be a very vascular cystic tumor. Marsupialization was attempted first.

MARSUPIALIZATION

This procedure is used in large cystic types of tumors where we are unable to mobilize them successfully without encroaching upon vital adjacent structures. The cyst is incised, the contents aspirated and the margins of the incision are sutured to the abdominal wall. The soft tissue behind the cyst tends to force it outward, obliterate the space it occupied, and the surface finally granulates.

However, on attempting to mobilize the cystic tumor of our patient it started to bleed and in spite of heroic attempts to stop the bleeding and replace the blood loss by transfusion the tumor kept oozing blood and it therefore had to be removed in toto. This proved to be technically extremely difficult because of its size and its close relationship to so many vital structures. By the time the mass was removed and the patient's incision closed, 42 pints of blood had been given. The patient died on the operating table.

In spite of the fact that our preoperative diagnosis proved wrong, I cannot see how we could have done otherwise. The history of trauma, the location of the lesion, the displacement of the adjacent hollow viscera, the absence of secondary symptoms or systemic reactions such as anemia, chills, fever or hematuria, all pointed to a pancreatic cyst. We commonly have two types of cysts: the so-called true cysts which are due to displaced cell rests or actually associated with the excretory ducts of the pancreas; and the pseudocysts which are produced as the result of trauma, associated with some hemorrhage and which enlarge gradually and often become much larger than the true cysts.

RUPTURE OF THE SPLEEN

Another disorder which may produce a large mass following trauma is rupture of the spleen with subcapsular hemorrhage, but here the patient is usually in shock with severe secondary anemia. A renal tumor could be excluded by the urinary findings, the absence of flank pain and the pyelogram.

As far as adrenal tumors are concerned we must differentiate between cortical and medullary tumors. Cortical tumors are usually large irregular tumors which tend to metastasize relatively early and which often produce a masculinizing effect which was not observed in this patient. We also frequently observe hypertension, which again was absent, and even the determination of the 17-ketosteroids did not give us a definite lead. The most common tumor of the adrenal medulla is the neuroblastoma. However, it occurs almost invariably in children up to five years.

Rarer types are the ganglioneuroma, the pheochromocytoma or paraganglioma. The latter tumor usually produces severe attacks of intermittent hypertension with blood pressure readings up to 300/110. The term *paraganglioma* infers that these tumors also can form from

the paraganglion cells along the vertebral bodies and therefore arise outside the adrenal glands. However, our diagnosis in this case was that of a traumatic pseudocyst of the pancreas and it was the only diagnosis which we could substantiate by all the clinical evidence previous to surgery.

CLINICAL DIAGNOSIS

1. Traumatic pseudocyst of the pancreas.

GENERAL CLINICAL DISCUSSION

DR. JACK WIDRICH: The calyces and the pelvis of the left kidney were somewhat widened and the left kidney shadow showed up larger and a little high in position as though the kidney were being pressed upon. Barium studies showed clearly that great big round calcified mass pushing the stomach upward, the colon downward, the small bowel toward the right and downward and it also flattended out the left kidney. Radiologically we thought it to be a pseudocyst of the pancreas secondary to trauma.

DR. HARDYMON: Dr. Widrich, have you found in your experience that tumors within a kidney displace the kidney anteriorly or posteriorly?

DR. WIDRICH: Kidney tumors often displace the kidney anteriorly in the same manner that other retroperitoneal tumors may do. The tumors arising from the adrenal very often displace the kidney down and laterally. A large spleen can put pressure on the kidney and flatten it out.

DR. H. B. MERKLE: Would you not have to consider some type of hydatid cyst because of the extensive calcification?

DR. HARDYMON: Large cystic tumors always show secondary calcification.

MEDICAL STUDENT: How about an Echinococcus cyst of the pancreas?

DR. HARDYMON: Well, in this part of the country I hardly think you boys would think about that. You see them occasionally down South but invariably they are in the liver.

DR. R. ASHARE: How significant do you consider the excretion of 150 mg. of 17-ketosteroids in 24 hours? Isn't that about ten times the normal amount?

DR. HARDYMON: We did not consider it excessive enough to influence our diagnosis.

DR. R. G. SALEEBY: I understand that this boy began shaving at 11 years of age and I wonder if this does not suggest some abnormal hormonal influence?

DR. HARDYMON: I am sorry but I was unaware of this fact.

DR. E. VON HAAM: What is the normal 24 hour excretion of 17-ketosteroids for adults?

DR. G. J. HAMWI: It varies between 11 and 14 mg. for women and between 14 and 20 mg. for men.

PATHOLOGIC DIAGNOSIS

1. Carcinoma of adrenal arising in ectopic adrenal tissue with metastasis to liver.
2. Massive intra-abdominal hemorrhage following surgery.
3. Terminal submucosal hemorrhages in trachea, stomach and kidney.
4. Partial pulmonary atelectasis.

PATHOLOGIC DISCUSSION

DR. VON HAAM: At autopsy we found the abdomen distended and the peritoneal cavity filled with 4,000 cc. of partly clotted blood. In searching carefully for the bleeding vessel we found numerous vessels which were oozing in the region of the tail of the pancreas. There also was one oozing vessel which could be identified as the intercostal artery of the left twelfth rib. It impressed us as one of the major bleeding vessels. The tumor itself had been completely removed and no trace of tumor tissue was found at the site of operation.

The heart was small and well contracted. The lungs were dry, ischemic and showed atelectasis at the base. The spleen appeared congested. The liver contained one large yellow nodule measuring 3 cm. in diameter which appeared to be definitely a metastatic tumor growth. The tail of the pancreas showed pressure atrophy and was surrounded by post-surgical blood clots. Numerous small hemorrhages could be found in the mucosa of the stomach and the mucosa of the large and small intestines.

The adrenal glands together weighed 12 grams. They appeared symmetrical and absolutely normal. The left kidney was slightly larger than the right. The perinephritic tissue showed numerous small hemorrhages. The kidney parenchyma appeared normal. The kidney pelvis and the ureter were not enlarged. The genital organs were consistent with the age of the patient and the tubules of the testicles strung easily. The retroperitoneal lymph nodes were not enlarged. The retroperitoneal tissue showed numerous small and larger hemorrhages.

From the autopsy we concluded therefore that all of the tumor with the exception of the metastatic growth had been removed, that the tissue did not arise in the adrenal, pancreas or kidney, and that the patient had died from severe hemorrhage during surgery.

The microscopic examination was chiefly concerned with the type of tumor, which was studied in the metastatic nodule found in the liver. The tumor tissue consisted of clear polyhedral cells of irregular and highly anaplastic type which formed groups of cell nests of varying sizes. The cytoplasm of the tumor cells was definitely vacuolar in appearance. The cell nuclei were

quite irregular; some of them were quite large, other cells possessed two or more nuclei. The tumor metastasis corresponded exactly with the histologic picture observed in the removed surgical specimen.

The histologic diagnosis of this tumor rested between two possibilities: that of a paraganglioma, an opinion which was expressed by our surgical pathologist, and that of a cortical carcinoma of the adrenal. In both instances an extra-adrenal origin of the tumor had to be assumed since both adrenal glands appeared perfectly normal. Special stains prepared for the purpose of differential diagnosis revealed that the vacuoles of the tumor cells contained material which stained like lipids and for this reason the cells were thought to contain steroid hormones.

For this reason it was then concluded that the tumor represented one of the rare cases of extra-adrenal adrenal carcinoma arising in accessory adrenal tissue. The occurrence of accessory adrenal tissue is not uncommon. In some animals, like rats, it is so common that the animals will survive bilateral adrenalectomy without much difficulty. In the human being it also can be found in many cases if searched for carefully. Accessory adrenal tissue can be distributed all along in the retroperitoneal fat tissue and can of course give rise to tumor formation.

Karsner[1] has described seven cases of extra-adrenal adrenal carcinoma. These tumors secrete steroid hormones which may either have an effect upon the genital development of the patient or may have other effects commonly attributed to adrenal steroids. In this particular patient no sexual precocity was observed but precocity of bone development, the muscular development and precocity of development of a beard could well be elicited from the history. We feel therefore that these facts together with the increased excretion of 17-ketosteroids speak strongly for the diagnosis of extra-adrenal adrenal carcinoma.

GENERAL DISCUSSION

DR. HAMWI: Do you feel that those tumors arise from displaced cell rests?

DR. VON HAAM: They do. I myself have encountered many such small islands of adrenal cells in the fatty tissue in both hypochondrial fossae and in the kidneys.

MEDICAL STUDENT: How do you explain the fact that the patient did not show a more pronounced degree of sexual maturity?

DR. VON HAAM: The effect upon the genital organs depends entirely upon the type of ketosteroids which are secreted by the tumor. The effect of course is always only upon the external genitalia and never on the testicle itself. In fact, hypogonadism may very well be produced when excessive cortical steroids depress the pituitary function. Unfortunately we could not examine the pituitary in this particular case but I am reasonably certain that the pituitary was not hyperactive.

DR. HARDYMON: Could you tell which vessel caused the fatal hemorrhage?

DR. VON HAAM: My assistants were quite definite about the intercostal artery of the twelfth rib on the left side. It was still oozing blood when the abdomen was opened at autopsy. Do you think it would be possible to bleed to death from an intercostal artery?

DR. HARDYMON: I believe so. These arteries fail to retract.

DR. VON HAAM: I really do not think that we should be too positive about it. There were many oozing bleeding points in the surgical field and the fact that the patient showed petechial hemorrhages in other places proves that the many blood transfusions had remarkably decreased the coagulability of the blood.

DR. H. D. SIRAK: How was the diagnosis of paraganglioma reached by the surgical pathologist?

DR. VON HAAM: Dr. Schlumberger probably made the diagnosis on the basis of the fact that a large extra-adrenal retroperitoneal tumor was present, that the cells had the irregular foamy appearance found in chromaffinomas and that the patient had no appreciable hormonal effect from this tumor. In contrast to this we maintain that certain hormonal effects could be demonstrated in the history and in the urine analysis and that the special stain showed definitely tumor cells rich in lipid material. Of course, extra-adrenal carcinomas are much rarer than paragangliomas and I am certain that very few of you will ever meet such a case again. It really represented a rare and unusual case which posed difficult diagnostic problems to the surgeon and pathologist alike.

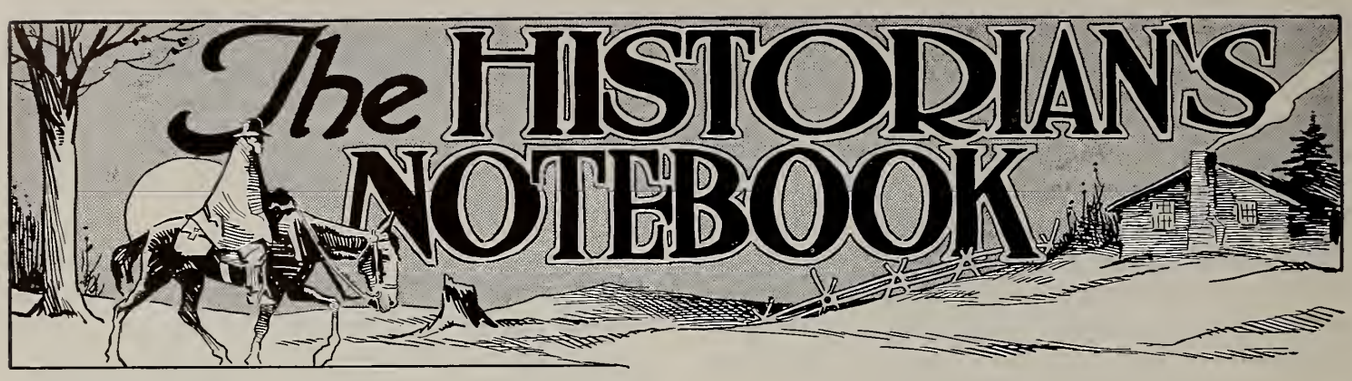
The only consolation that we can take from the case was the fact that the metastasis proved that the boy was doomed regardless of how successful the operation might have been.

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Vaccination Against Influenza

It should be emphasized that vaccination against influenza cannot be expected to protect against the noninfluenzal diseases such as the ordinary bronchitis or the common cold, the etiologies of which are probably diverse and certainly obscure.—Dorland J. Davis, M. D., Bethesda, Md.: *M. Ann. District of Columbia*, 22:643, December, 1953.



James T. Whittaker, M. D., of Cincinnati*

ALFRED H. WHITTAKER, M. D., Detroit, Mich.

THE *Allgemeine Medicinische Central Zeitung* and the *Berliner Klinische Wochenschrift* of April 1, 1882, contained brief references to the discovery of Doctor Robert Koch of the Bacillus of Tuberculosis. The full text of the discovery was published in the *Berliner Klinische Wochenschrift* in the issue of April 11, 1882.

At the meeting of the Academy of Medicine of Cincinnati, May 1, 1882, Doctor James Thomas Whittaker of Cincinnati, who had been appointed Professor of the Theory and Practice of Medicine and Clinical Medicine at the Medical College of Ohio in 1879, called attention to the members "to the recent discovery in medicine, a discovery which is a triumph in science that will probably ultimately give us the means to eradicate one of the deadliest scourges of our race."

Within a month Doctor Whittaker was in Berlin studying in Koch's laboratory and establishing a friendship which years later led to the dedication of the Whittaker text book in Medicine to Robert Koch.

By the time the fall session of the College opened, the Doctor[4] was home fully prepared to demonstrate the teachings of Koch, and in 1890 when Koch introduced tuberculin, Doctor Whittaker made the first use of it in America.

On the first of April 1887, Koch published an article in the *Deutsche Medicinische Wochenschrift* on the new tuberculin—Tuberculin R. In the *Ohio Medical Journal* for May, June, and October, 1897, articles appeared on this subject by Doctor Whittaker, the latter being a paper read before the British Medical Association at its meeting in Montreal in September, 1897.

EDUCATION IN OHIO

Medical education in Northern Ohio was influenced by teachers from New England, especially Harvard, Yale, and Dartmouth. In 1834 Willoughby University of Lake Erie was incorporated in Chagrin. The school was named after Westel Willoughby, the president of Fairfield Academy. The academy attracted well known teachers of ability and the enrollment steadily increased, but, after graduating 555 physicians, the medical school was closed.

The traditions of the academy were carried on at Willoughby, four of the incorporating physicians having been pupils of President Willoughby. The school closed at the end of the 1846-1847 session, and its equipment was moved to Columbus. In 1848 the provision in the charter permitting medical teaching was annulled, and under a new charter, Starling Medical College replaced the transported institution. In time, another school, the Ohio Medical University, was joined to the Starling school under the name of Starling-Ohio Medical College, Doctor W. J. Means being the Dean. In 1913, the school became the Medical College of Ohio State University, and birth was given to the magnificent health center on the Ohio State Campus.

Although there is a strong influence deriving from New England in Central Ohio medicine, the proximity of the Medical Center in Cincinnati also brought to bear the teachings of that center to which the writer can attest. In his own experience as a student of both Starling-Ohio, and of Ohio State University, frequent references were made to the numerous nationally recognized teachers at the Medical College of the University of Cincinnati, where the influence was that of Pennsylvania, Virginia, Great Britain, and the European Medical Centers.

Francis Packard[2] has shown that there have

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* Read before the Twenty-sixth annual meeting of the American Association of the History of Medicine, Columbus, Ohio, April 11, 1953.

been well defined periods in which young medical men went to various medical centers for their graduate work. During the colonial period to 1800 the majority went to London and Edinburgh because they regarded Great Britain as the Mother Country, but also because those centers were at the zenith of their fame.

After the French Revolution, Paris became the great medical center, the famous clinicians of that city drawing graduate students from all countries. By 1850, however, the majority of American students were spending the major part of their time in Germany and Austria.

The influence of the English speaking medical centers was present when the first medical college was founded (1765) in this country, the College of Philadelphia, now the University of Pennsylvania.

The teaching and discoveries of the French investigators and the German scientists had been introduced by the time (1866) James Whittaker was graduated from the University of Pennsylvania. But the British influence was predominant, and the Doctor's frequent visits to France, Germany, and Austria, added the great contributions being made by the scientists of those countries to the teachings of medicine in Southern Ohio and indirectly to Central Ohio, as has been mentioned.

DOCTOR WHITTAKER'S INFLUENCE ON MEDICAL EDUCATION

Doctor Whittaker's influence on medical education was exerted early. In April, 1868, he sailed from New York for Bremen, and reached Berlin on the eighth of May where he immediately entered the lectures of Langenbeck on Surgery; Edward Martin on Obstetrics; Graefe, Virchow, Traube, and Du Bois Raymond, on Physiology. At the end of the semester, the Doctor went to Prague to study Obstetrics clinically.

In January, 1869, he moved on to Vienna. In that city Rukitansky, the great rival of Virchow, was lecturing. Hyrtle, the anatomist, eloquent and dramatic, made his subject positively interesting. Skoda, the great authority on diseases of the lungs, was lecturing; and Billroth was just coming into his great and deserved fame. Carl Braun, in Obstetrics, was aging and Spaeth was the coming man in that department. Doctor Whittaker soon secured a room in Spaeth's department of the General Hospital, so as to be in constant attendance when patients were in labor or when operations were performed.

Time was available for trips to Switzerland, to Italy, and Paris. During these travels Doctor Whittaker wrote interesting accounts of the trips which were published in the Cincinnati papers.

TEACHER—LECTURER—AUTHOR

By the first of October, 1869, Doctor Whittaker was back in Cincinnati, opened an office and immediately was made Assistant Professor of Obstetrics and Diseases of Children in the Medical College of Ohio, starting a teaching career which lasted thirty years.

With a background of medical education in the Philadelphia medical center, with training received under the great European masters, by his carefully prepared lectures to his students over the years, by his vast number of contributions to the medical literature, his membership and participation in the meetings of the Cincinnati Academy of Medicine, the American Academy of Medicine, the Association of American Physicians, as a Fellow of the College of Physicians of Philadelphia and Fellow of the Chicago Academy of Medicine, as chairman of the Section of Practice of Medicine of the American Medical Association, the Doctor wielded a strong influence on the advances and dissemination of medical knowledge—not only in Ohio, but throughout the country.

His friendship with Osler, S. Weir Mitchell, Frank Billings, Howard Kelly, and leaders in the medical profession in European countries, and his visits to those countries kept him constantly abreast of the constantly expanding medical sciences and his brilliant lectures and facile pen enabled him to guide the methods of medical teaching.

FAMILIARITY WITH ANCIENT PHILOSOPHY AND THE HISTORY OF MEDICINE

The writings of Doctor Whittaker reveal a knowledge and familiarity with the ancient philosophers and the history of medicine.

In 1835 J. Bostack,[5] M. D., F. R. S., had published a *Sketch of the History of Medicine*, and in 1856 John Watson, M. D.,[6] delivered an anniversary discourse "The Medical Profession in Ancient Times" before the New York Academy of Medicine, and it was the current publication of such papers which played an important part in molding Doctor Whittaker's cultural and historical interests, just as a knowledge of the rapidly unfolding scientific advances of the latter half of the Nineteenth Century influenced his investigative tendencies to search out the cause of disease.

He was familiar with the encyclopedic writing of Celsus, followed years later by the writings of Theophrastus von Hoheneim, called Paracelsus; with the work of Ramazzini who was followed at the University of Padua by Morgagni; with the Scientific Revolution starting in the Seventeenth Century, the works of Antoine Lavoisier, scientist, economist, and social reformer, who contributed in 1789 *Elements of Chemistry;* with Jean Fernal, who in 1554 used the word "physiology" as a substitute for what he had in 1542 styled *naturalis pars medicinae.* In its scope he included the normal structure and functioning of the human subject. The intimate cellular structure of

the body became known from 1830 onward. The miscroscopic examination of tissue gave rise to new ideas of functioning.

SCIENTIFIC FOUNDATION OF MEDICAL EDUCATION

Thus James T. Whittaker's career coincided with the advent of physiology, and his studies brought him into contact with the teaching of Claude Bernard, and of his predecessor Francois Magendie, a pioneer in experimental physiology and scientific medicine.

Charles Edward Brown-Séquard, born April 8, 1817, had by 1852 established a prominent place among Nineteenth Century physiologists. His work was familiar in the United States as a result of his attendance at the Richmond meeting of the American Medical Association, and publication of his discoveries in Neurology. In 1854 the Medical College of Virginia had been granted a charter and in 1854 Brown-Séquard was appointed to the chair of Physiology, to carry on his great work in the field of experimental physiology.

Louis Pasteur had been born on December 27, 1822, the same year the accident to Alexis St. Martin on Mackinac Island had resulted in experiments on the physiology of the stomach by William Beaumont.

On May 5, 1881, Pasteur began a series of public investigations to prove the ability to immunize sheep against anthrax. Koch, who disliked Pasteur, attempted to deprive Pasteur of credit for the discovery. James Whittaker, visiting with Koch, undoubtedly was familiar with this work—possibly was influenced in the emphasis which, in his *Theory and Practice*, he placed on Bacteriology, and the cause of disease.

Two hundred years before the days of Bacteriology, Boyle suggested that some diseases are due to micro-organisms, but it received no substantial confirmation until Schoenlein—with the aid of a microscope—discovered the infectious nature of ringworm.

Davaine,[7] while assisting the clinician Rayer, in the study of the devastating anthrax plague in 1850, observed little thread-like bodies in the blood of animals dead of the disease. The superior technique of Koch was required to obtain the anthrax organisms in pure culture, to follow the cycle of their development in the animal body, and thus to place the important discovery of Davaine on a scientific foundation.

In 1827, Joseph Lister was born and by 1854 he was searching for methods of improving wound healing. In 1856 a colleague, Thomas Anderson, Professor of Chemistry, drew Lister's attention to the work of Pasteur, resulting in his later work. On August 12, 1865, the first case (a compound fracture of the leg in a boy) was treated by Lister and sepsis prevented, this occurring at a time when Doctor Whittaker was completing his formal training and just before his European studies.

Paul Ehrlich was born in March, 1854. Since his contributions to science began at an early age, his first dissertation "Contributions to the Theory-Practice of Histological Staining" appeared in 1877. While Ehrlich did not lecture in this country until 1904, he had been given professorial rank in 1884, had a small research laboratory of his own in Berlin, but accepted an invitation from Robert Koch to work at his newly created Institute for Infectious Diseases at Berlin. Here, where James T. Whittaker had also worked, his studies in immunity were of great importance to Emil von Behring's discovery of Diphtheria Antitoxin.

In the United States, Benjamin Rush[8] had created a chain of medical influence which passed through Daniel Drake, his pupil, to James Whittaker, who later occupied the same chair in Medicine.

Benjamin Rush[8] was born January 4, 1746, and educated by preceptorship with Doctor John Redman, during which time the College of Philadelphia was formed and he attended lectures in that institution. He began the study of medicine in 1761, and worked and studied until 1776. In August of 1766, he sailed for Liverpool, and proceeded to Edinburgh where two years were spent in medical lectures, attendance at the Infirmary, and in perfecting a knowledge of Latin, a closer acquaintainship with the classics, and with the aid of a tutor, learning French, and an ability to read Italian and Spanish. These two years, 1767-1769, influenced Rush's entire career and brought to Philadelphia the methods of British medicine which were to affect American teaching for many years.

DANIEL DRAKE

Daniel Drake[3] was born October 20, 1785, and soon his father moved to Kentucky. From birth his father planned for him to become a physician. Having become acquainted with a Doctor Goforth, who moved to Cincinnati in 1800, the 15 year old Daniel was sent to him to "take up" medicine. He worked diligently and was given a signed diploma by Doctor Goforth and in 1805 went to the only school of any importance, the University of Pennsylvania. He attended lectures by Rush, and others, but the experience was a disappointment. After six months, making no effort to secure a diploma, he returned to Cincinnati. He married, developed a charm of manner, a great interest in the mid-west, and a passion to develop in Cincinnati the great medical teaching center of the West.

By 1815 he had not received an authentic diploma so he went back to Philadelphia. Already widely known for his writings on conditions in the West, he studied hard and in a few months secured a diploma from the University. In May

1816 he returned to Cincinnati where he was to remain except for periods of time at Transylvania where he occupied the chair of Materia Medica and Botany, (later the Chair of Theory and Practice of Medicine), and in 1830, the Chair of Medicine of Jefferson College in Philadelphia for less than a year, and later, the same chair at the University of Louisville.

Drake soon (1819) set about promoting a medical school and by 1820 the faculty was engaged and the Medical College of Ohio came into existence. Thirty years after founding the Medical College of Ohio, Drake was again back at that school. Once again he was called to Louisville, but 1852 found him again in Cincinnati only to die of acute meningitis.

BIOGRAPHICAL DATA

James T. Whittaker was nine years of age at the time of Drake's death. On this foundation of medical education developed men in the next generation such as Osler, Whittaker, S. Weir Mitchell, Welsh, and Cushing, men characterized by high intellectual attainments, brilliant ability as teachers, collectors of fine libraries, linguists, and leading citizens in their communities.

Doctor Whittaker, aside from the part he played in interpreting medical progress, presents an interesting study:

Son of James Whittaker and Oliva S. Lyon, he was born March 3, 1843, in Cincinnati, Ohio.

James Lyon, Doctor Whittaker's maternal grandfather, was a physician and linguist of much repute. He served as a surgeon in the Mexican War. Doctor Whittaker, who inherited his talents, as a child was a serious student. He had a rare memory and mastered Greek and Latin at an early age, and in later years, modern languages came easily.

In 1859, he entered Miami University. He saw some action in the defense of Cincinnati against the Confederate army, and returned to the University to be graduated in 1863.

He was appointed, apparently without any formal medical training, Acting Assistant Surgeon in the United States Navy, and continued to be in this work until discharged October 10, 1865. During leaves of absence he studied medicine, being graduated in Medicine at the University of Pennsylvania in 1866, probably the first student trained in Medicine while in government service.

In 1867, he was graduated from the Medical College of Ohio, and was appointed chief resident physician to the Commercial Hospital. Reference has been made to his first European studies undertaken the following year.

Outstanding ability resulted in rapid advancement from his first appointment as assistant professor of Obstetrics and Diseases of Children, including lecturing on Embryology, and the following year he gave a course on operative obstetrics.

In 1869 he was appointed pathologist to the Good Samaritan Hospital which position he retained for four years, which work is significant when his future writings are considered.

The degree of Master of Arts was conferred on him by Miami University in 1870, the same year he was appointed Professor of Physiology in the Medical College, a chair which his earlier studies had well prepared him for. In 1871, clinical medicine was added to his chair and in 1879 he was appointed Professor of the Theory and Practice of Medicine and Clinical Medicine, which position he held until his death in 1900.

Doctor Whittaker continued a student until his death. While studying languages during his years of active practice, he took his teachers with him in his carriage, reading, and conversing in the interval between visits.

He had a fondness for poetry, wrote at least one well-known novel, *Exiled for Lése Majasté*, was a prolific contributor to the medical literature of this country for thirty years.

He was the editor of the *Clinic*, a very popular publication from its origin in 1871. His lectures and original contributions appeared constantly in the medical journals of his time, the *Journal of the American Medical Association*, the *Cincinnati Lancet Clinic*, and the *Ohio Medical and Surgical Journal*, the *Cincinnati Medical News*, the *Louisville Medical News*, the *Philadelphia Medical News*, the *Obstetric Gazette*, the *Detroit Lancet*, of September 1880, the *Cincinnati Medical and Dental Journal*, *Philadelphia Reporter*, *Philadelphia Medical Times*, and the *Medical Record* (New York) all publishing his writings.

At one time Doctor Whittaker was Associate Editor of the *International Medical Magazine*.

In 1870, the *American Journal of Obstetrics* published his paper "The Morbid Anatomy of the Placenta," a prize essay for which he was awarded one hundred dollars in the first year of his teaching.

In addition to these contributions he published a vast number of articles in the various systems of medicine and handbooks, and an amazing number of minor papers and addresses read before scientific and literary bodies.

Doctor E. W. Mitchell, a pupil of Doctor Whittaker, still living in Cincinnati, now after 60 years speaks of the fine personal characteristics of his teacher, the brilliance of his lectures which held the rapt attention of the students, of his rapid flow of language in which he was never at a loss for the proper term, of his use of visual aids, and of his constant references to the classics. Many of his lectures were introduced by outlining the historical background of the subject and by reference to the work of other clinicians in every part of the world.

Doctor David A. Tucker, Jr., has spoken of the

confidence of the patients in Doctor Whittaker and their willingness to follow his directions.

Doctor Harry Spargur, who also is living in Cincinnati, remembers vividly the brilliance of the lectures, the kindliness of this great teacher.

Doctor Whittaker's greatest contribution was his text book *Theory and Practice of Medicine* published by William Wood and Company in 1893, a standard text used in many colleges for years. The book, published one year after Osler's *Practice of Medicine*, is well illustrated and incorporated the bacteriological and physiological aspects of medicine in a way far superior to any text book of its period.

Doctor Whittaker died on June 5, 1900, of carcinoma, being aware, from the beginning of his illness, of the hopelessness of his condition and knowing that medicine had nothing to offer to effect a cure.

MEMORIALS

On June 25, 1900, the Academy of Medicine of Cincinnati held a memorial meeting at which Doctor A. G. Drury presented a biographical sketch and communications were received from friends and admirers throughout the country.

The resolution of the American Medical Association read in part: "Moved by Doctor Osler, seconded by Doctor Frank Billing: That in the death of Doctor James T. Whittaker of Cincinnati, the profession of this country has lost one of its most distinguished ornaments and the section of medicine of this Association an earnest and faithful member."

It is no longer necessary for students of medicine to travel to far parts of the world to secure the best of medical teaching, due to the devotion and sacrifice of American physicians such as Doctor James T. Whittaker. By their efforts they brought to America the medical knowledge of all countries and developed institutions and standards of medical education which have resulted in this country not only assuming leadership in scientific research but in the practical application of medical care which provides America with a standard of health unknown in all the history of the world.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Ankle—Literally meaning the bend of the leg or claw, this term is derived from the Anglo-Saxon word "ancleow." This in turn probably comes from the root "ang or ank" meaning a bend or angle, plus "claw."

Chest—Derived from the Anglo-Saxon word "cest" via the Latin "cista" and the Greek "kiste" meaning a basket or a box, this term was descriptively applied to the thorax because it is the box-like cavity of the body containing the lungs.

Epistaxis—An ancient term used since the days of Hippocrates to designate the act or state of bleeding from the nose. The term literally means a "dropping upon" and is composed of the Greek words, "epi," or upon, and "stazein," to drop.

Medical—Medicine—These terms which relate to the art and science of healing come from the Latin words "medicina and medicus," designating a healer. These words in turn come from the Latin "medeor," I heal. In Spanish and Italian a doctor is termed a "medico."

Asylum—This Latin word comes from the Greek word "asulon" which is composed of the Greek "a," or not, and "sulao," I rob or plunder. The term "asulon" was originally used in ancient Greece to designate those temples, altars or sacred groves which possessed the privilege of sanctuary and gave safe refuge to fleeing slaves, debtors, and criminals. Hence the term came to be extended to mean a hospital or refuge for the insane. The word appeared in English in about 1500.

Decrepit—When you are old and decrepit you are so broken down by the infirmities of age that you are literally unable to make any noise, either by footstep or voice. The word "decrepit" came into English via the French and derives from the Latin "de," or not, plus "crepito" meaning to rattle or to clatter.

Eunuch—The Greek word "eunouchos" means one who is castrated and is composed of the Greek words "eune," a bed, and "echo," I have or keep. In the East or Orient it was the ancient custom to place a castrated man in charge of the women's quarters of a harem. It is said that "eunuchs" were first used by Semiramis an Assyrian Queen in about 2,000 B. C.

Examine—Examination—The Latin noun "exagmen" designated the tongue of a balance used for weighing and from this came the Latin word "examinare" meaning to try by weight. Hence when the doctor examines a patient he literally makes a careful observation and inspection of the patient as if he were "weighing the patient's physical condition."

—Harry Wain, M. D., Mansfield, Ohio.

The Ohio State Heart Association; a Voluntary Health Agency for Research, Education and Community Service

By BERNARD A. SCHWARTZ, M. D.
President of the Ohio State Heart Association

THE OHIO STATE HEART ASSOCIATION, the direct affiliate here in Ohio of the American Heart Association, was organized in January, 1951, for the purposes of promoting medical and lay knowledge on control of cardiovascular diseases and to coordinate programs of its affiliated corporations.

The formation of this organization was a natural outgrowth of the revitalized American Heart Association which approximately six years ago broadened its scope from generally a scientific council to a national voluntary health agency.

The physicians who composed the American Heart Association at that time realized that to successfully carry on a program of research, education and community services throughout the nation lay participation would be necessary and a yearly fund raising campaign would have to be conducted to insure such a program.

Today the American Heart Association, the Ohio State Heart Association and most of its chapter affiliates have equal medical and lay representation on their boards, with the doctor concerning himself principally with medical and public health matters and the layman with the administration, public relations and the raising of funds.

RESEARCH

Last year over one-half of the funds raised by the chapter heart associations were allocated for research. The need for more and more funds to support this is obvious.

It is the feeling of the Ohio State Heart Association that the bulk of research must, of necessity, be conducted at the medical centers in the state. However, it has a strong conviction that many projects on a local level particularly in the field of preventing heart disease can and should be carried on in other areas.

PROFESSIONAL EDUCATION

The educational program of the heart association not only concerns itself with the matter of lay education but, in particular, with professional education. Joint meetings with county medical societies, symposia, special literature, scientific films are some of the activities carried on by the heart association in this field. A statewide speakers bureau for both lay and medical groups is now being formed and many of the chapter heart associations have them for their areas.

COMMUNITY SERVICES

The third major phase of the heart association program—community services—is what the name implies. The Cardiac-In-Industry Program with the work classification unit as developed by the Cleveland Area Heart Society, the Rheumatic Fever project being conducted by the Youngstown Area Heart Association, the Heart of the Home Program to save steps for the cardiac housewife which is being operated by a number of heart associations in Ohio, the promotion of and assistance to cardiac clinics for the medically indigent in Cincinnati, all are types of community service programs.

> Dr. Schwartz has responded to an invitation of *The Journal* by furnishing readers with authentic and factual information on the organization, policies and purposes of the Ohio State Heart Association. This and other articles in this issue on the heart are appropriate at this season when a nation-wide educational program to combat heart disease is under way. *The Journal* in November featured diabetes—in this issue, the heart. In succeeding issues it will play a part in other worthy programs sponsored in the interest of the health of the public.

The Ohio State Heart Association and its chapter affiliates throughout Ohio need and desire all assistance they can get from the medical profession both individually and collectively. It is aware that it is a young organization with tremendous tasks and responsibilities before it and fully realizes that only through constant surveillances, cooperation and constructive criticism from the physicians in Ohio can it be totally successful.

School Health Film

How a typical town in Oklahoma recognized its school health problems and, through community effort, launched a plan to solve them is the subject of a new film which has been added to the A. M. A. motion picture library.

"School Health in Action"—a sound and color film—was produced for the Oklahoma State Department of Health with the cooperation of the Oklahoma State Medical Association. The service charge for this film is two dollars. Requests should be made to the A. M. A.'s Committee on Medical Motion Pictures.

Have You Secured Special Train Space?

Better Hurry, As Reservations Are Pouring In For Accommodations on Big All-Expense Trip to West Coast, A. M. A. Meeting, June 12 - July 3

ON THIS and the following page are views of a few of the points of interest which will be visited by Ohio physicians and members of their families who will be aboard the Ohio State Medical Special Train to San Francisco next June when the American Medical Association meets in the Golden Gate City.

Reservations for the Special Train are pouring into the Columbus Office. If you are thinking of going, better get in touch with Executive Secretary Nelson immediately and secure a special folder, telling all about the trip, and a reservation blank.

Space on the all-room, air-conditioned Special Train will be assigned on a "First Come, First Served" basis.

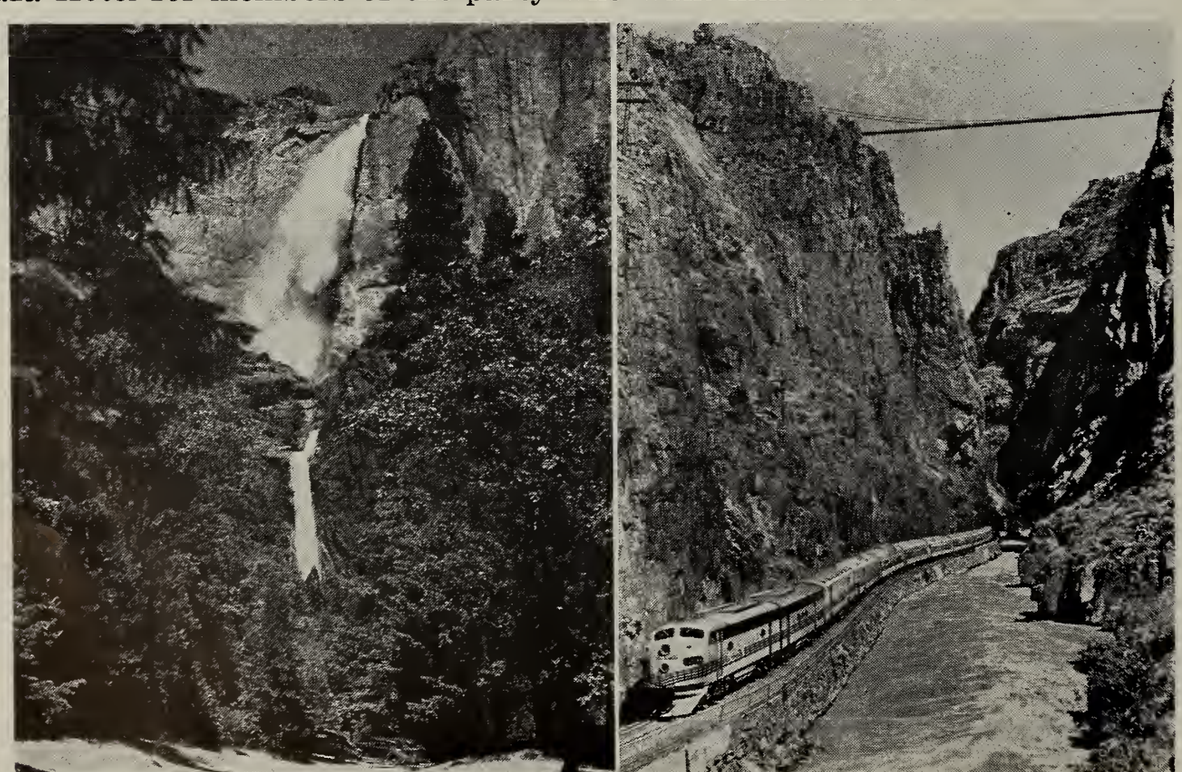
The Special Train will leave Chicago on June 12 and return to Chicago on July 3.

The Ohio party will travel to San Francisco by way of Denver, the Royal Gorge, Salt Lake City, Los Angeles and Yosemite National Park. There will be plenty of sightseeing and fun in Salt Lake City, Los Angeles and Yosemite National Park.

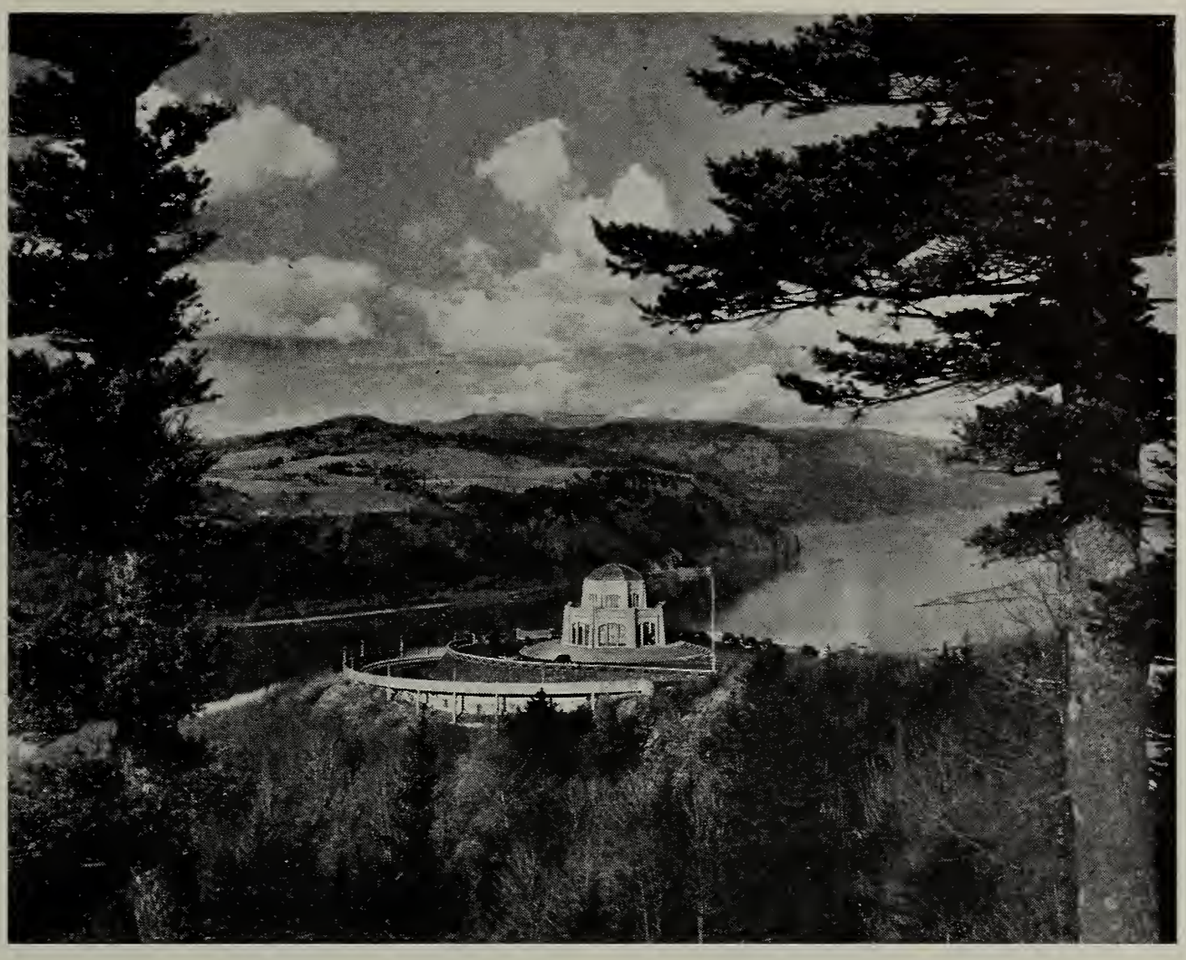
After the A. M. A. meeting in San Francisco, the O. S. M. A. Special will pull out of the Golden Gate City on June 25. En route home, the party will stop at Portland for the famous Columbia River Highway drive, including Multnomah Falls and Bonneville Dam. From there, the train will travel through the very heart of the Northwest Rockies. There will be three days and three nights at grand and glorious Glacier National Park.

The cost of the all-expense trip will be approximately $500 per person, depending on the kind of Pullman space selected and *exclusive* of meals and sightseeing at Los Angeles and San Francisco, hotel in San Francisco, one meal in Portland and round-trip rail and Pullman fare between home city and Chicago. Everything else, even tips, will be included in the all-expense cost.

Mr. Nelson will secure hotel space in San Francisco at either the Drake-Wiltshire or Plaza Hotel for members of the party who want him to do so.



YOSEMITE FALLS AND ROYAL GORGE



CROWN POINT IN THE COLUMBIA RIVER GORGE



MANY GLACIER HOTEL, GLACIER NATIONAL PARK

Annual Meeting Guest Speakers . . .

Features of the Columbus Meeting, April 12 thru 15 Will Include Ten Out-of-State Guest Speakers, Each a National Headliner in His Field

THE OHIO STATE MEDICAL ASSOCIATION has been fortunate in securing 10 outstanding out-of-state guest speakers for the 1954 Annual Meeting in Columbus, April 12-15. Sessions will be at the Neil House and Deshler Hilton Hotels.

In order that physicians attending the meeting may have maximum advantage in hearing these guests, arrangements have been made to have each speak before a Specialty Section and again before a General Session.

It should be emphasized that Specialty Section Programs are arranged by the respective specialty members, but are designed in many instances to appeal to physicians in all branches of practice. All sessions are open to all physicians.

The complete program for the 1954 Annual Meeting will be published in the March issue of *The Journal.*

Following are brief biographical sketches of out-of-state speakers and the subjects on which they will speak.

Joseph C. Bell, M. D., Louisville, Ky., is a diplomate of the American Board of Radiology and is professor of roentgenology, University of Louisville School of Medicine and chief of Department of Radiology, Norton Memorial Infirmary. A graduate of Harvard Medical School, Class of 1923, he holds memberships in numerous professional organizations, among them the American Roentgen Ray Society, past-president, the Radiological Society of North America, member of Board of Chancellors of the American College of Radiology.

Dr. Bell will speak before the Section on Radiology on Wednesday, April 14, on the subject, "Intravenous Urography—Indications and Contraindications—Contrast Media — Reactions." On Thursday, April 15, he will speak before a General Session on "Radiological Problems in Trauma of the Head and Neck."

Stewart H. Clifford, M. D., a practicing physician of Brookline, Mass., a graduate of Harvard Medical School, Class of '25, is assistant clinical professor of pediatrics, Harvard Medical School. He is a diplomate of the American Board of Pediatrics and is a member of the American Pediatric Society, the American Academy of Pediatrics and the New England Pediatric Society.

His first appearance will be before the joint meeting of the Section on Obstetrics and Gynecology and the Section on Pediatrics, on Tuesday, April 13, where he will speak on "The Post-Mature Infant—A Clinical Syndrome Due to Placental Dysfunction." His second appearance will be before a General Session on the same day to discuss the subject, "Common Problems in the Newborn Infant."

Urban H. Eversole, M. D., is director of the Department of Anesthesiology, Lahey Clinic, Boston. He is a graduate of the University of Kansas School of Medicine, 1932, is a diplomate of the American Board of Anesthesiology and a member and past-president of the American Society of Anesthesiologists, Fellow, American College of Anesthesiologists.

"Lumbar Puncture Headache," will be his subject before the Section on Anesthesiology on Wednesday, April 14. On Thursday, he will speak on the subject, "Anesthesia Problems in the Geriatric Patient," before a General Session.

Frank H. Krusen, M. D., Rochester, Minn., is professor of physical medicine and rehabilitation, Mayo Foundation of the University of Minnesota, and head of the Section on Physical Medicine and Rehabilitation, Mayo Clinic. Also he is consultant to the St. Mary's and Methodist Hospitals of Rochester. Dr. Krusen is this year's choice of the national commission on employment of the handicapped to receive the President's Award for work in that field. He also is chairman of the A. M. A. Council on Physical Medicine and

G. P.'s Can Get Five Credit Hours By Attending O. S. M. A. Meeting

The 1954 Annual Meeting of the Ohio State Medical Association, April 12-15, in Columbus, offers an excellent opportunity for physicians in general practice who are members of the Ohio Academy of General Practice to secure additional credits for approved post graduate work.

The Academy has announced that it will allow five credit hours to members who take advantage of the fine program which will be offered at the State Association meeting.

Rehabilitation. A graduate of Jefferson Medical College of Philadelphia, 1921, he is a diplomate of the American Board of Physical Medicine and Rehabilitation; past-president of the American Society of Physical Medicine and Rehabilitation; past-president of the American Congress of Physical Medicine and Rehabilitation; past-president of the International Federation of Physical Medicine.

Dr. Krusen will speak on the subject, "Laboratory Studies on the Use of Ultrasonics in Medicine," on Wednesday, April 14, before the Section on Physical Medicine, and on Thursday will speak before a General Session on "Physical Medicine and Rehabilitation for Chronic Illness."

William Likoff, M. D., Philadelphia, associate professor of medicine, Hahnemann Medical College, is a diplomate of the American Board of Internal Medicine. He is a graduate of Hahnemann Medical College and Hospital, 1938.

He will address the Section on Internal Medicine on Wednesday, April 14, using as his topic, "Medical Aspects of Cardiac Surgery." On the following day, he will discuss "Newer Concepts of Coronary Circulation" before a General Session.

George C. Prather, M. D., Brookline, Mass., a practicing physician, is head of the Department of Urology, Beth Israel Hospital, Boston, and consultant in urology, Boston Lying-In Hospital. He is a graduate of the Harvard Medical School, 1924; diplomate of the American Board of Urology; member, New England Surgical Society, American Association of Genito-Urinary Surgeons, American Urological Association, American Clinical and Climatological Association, and the American College of Surgeons.

"Surgical Treatment of Renal Cysts," will be his subject before the Section on Urology on Tuesday, April 13. He will speak before a General Session on Wednesday on the subject, "Urological Problems During Pregnancy."

Harold G. Scheie, M. D., Philadelphia, a diplomate of the American Board of Ophthalmology, is professor of ophthalmology, Hospital of the University of Pennsylvania, consultant in ophthalmology, Valley Forge Hospital and Walter Reed Hospital; Central Office chief consultant in ophthalmology for the Veterans Administration. He is a member of the American College of Surgeons, College of Physicians of Philadelphia, American Academy of Ophthalmology and Otolarygnology, American Ophthalmology, Association for Research in Ophthalmology, Association of Military Surgeons. He is a graduate of the University of Minnesota Medical School, 1935, and completed a course at the Graduate School of Medicine, University of Pennsylvania, in 1939.

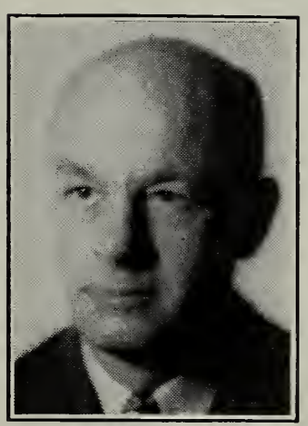
Before the Section on Ophthalmology, on Tuesday, April 13, he will discuss, "The Surgical Treatment of Glaucoma." On Wednesday, before the General Session he will speak on the subject "Retinal Changes of Hypertension and Arteriolarsclerosis."



JOSEPH C. BELL, M. D.
Louisville, Ky.



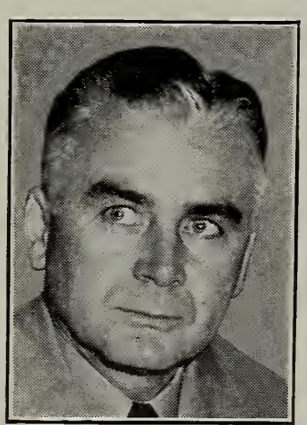
FRANK H. KRUSEN, M. D.
Rochester, Minn.



G. C. PRATHER, M. D.
Brookline, Mass.



E. L. SEVRINGHAUS, M. D.
Nutley, N. J.



HAROLD G. SCHEIE, M. D.
Philadelphia



H. B. SHUMACKER, Jr., M. D.
Indianapolis

Elmer L. Sevringhaus, M. D., is director of clinical research for Hoffmann-LaRoche, Inc., pharmaceutical manufacturers of Nutley, N. J. Graduate of Harvard Medical School, 1921, he is a diplomate of the American Board of Internal Medicine; member, Central Society for Clinical Research, Association of American Physicians, American College of Physicians, American Psychosomatic Society, American Institute of Nutrition, American Society of Biological Chemists, director of Endocrinology and Metabolism, Jersey City Medical Center.

"Endocrine Factors in Obesity," will be discussed by Dr. Sevringhaus on Tuesday, April 13,

before the Section on General Practice. On Wednesday, he will talk on "Prescribing Adequate Nutrition," before a General Session.

Harris B. Shumacker, Jr., M. D., is professor and chairman of Department of Surgery at Indiana University School of Medicine. He is a graduate of Johns Hopkins University School of Medicine, 1932; diplomate, American Board of Surgery; member, American Surgical Association, Society of Clinical Surgery and Society of University Surgeons, Central Surgical Association, Society of Vascular Surgery, American Thoracic Surgical Association, International Society of Surgery and International Society of Angiology.

Dr. Shumacker speaks to the Section on Surgery on Tuesday, April 13, on the subject, "Surgical Considerations in the Treatment of Injuries and Diseases of Peripheral Arteries." His General Session subject, also on Tuesday, will be "The Management of Venous Thrombosis and Its Consequences."

Harry L. Williams, M. D., Rochester, Minn., is head of the Section on Otolaryngology and Rhinology at Mayo Clinic. Dr. Williams is a graduate of the University of Pennsylvania School of Medicine, 1924; diplomate of the American Board of Otolaryngology; professor of otolaryngology and rhinology, Mayo Foundation Graduate School, University of Minnesota; member, American Academy of Ophthalmology and Otolaryngology; American Otological Society, Inc.; American Laryngological, Rhinological and Otological Society, Inc.,—past-vice-president of the Middle Section of the society; and member of the Editorial Board of the American College of Allergists.

"Vertigo," will be his subject for discussion before the Section on Otorhinolaryngology, on Wednesday, April 14, and "The Headache Problem" before the General Session on the same day.

Neurological Surgery Program On Annual Meeting Agenda

The Council of the Ohio State Medical Association has authorized establishment of the Section on Neurological Surgery and the Committee on Scientific Works has arranged a program to be conducted by this Section at the 1954 Annual Meeting in Columbus.

The Section has arranged an excellent program for Wednesday morning, April 14, which will be a symposium on the subject of "Intracranial Hemorrhage." The program will be gauged to appeal to physicians in all branches of practice, but especially to general practitioners and internists.

Watch for complete details, including names of speakers, in the March issue.

Industrial Health To Be Conference Topic

Health problems of the worker and his family will be discussed at the 14th annual Congress on Industrial Health, to be held February 23-25 at the Brown Hotel, Louisville, Ky., under the sponsorship of the American Medical Association's Council on Industrial Health.

The role of industry in the maintenance of the health of the nation will be the subject of the opening general session on Wednesday morning, February 24. The keynote will be that industry and medicine are partners, it was announced by Dr. Carl M. Peterson, Chicago, secretary of the council.

In the afternoon, a clinic on health programs for executives will be presented. The value of screening examinations also will be discussed.

On Thursday morning, February 25, the problems of a small plant operator will be considered. The National Safety Council's small business and associations committee will assist. This will be followed by a presentation of how a plant can prepare for emergencies. The Louisville Chapter of the American Red Cross will participate in the program.

In the afternoon, a joint session with the A. M. A.'s Council on National Emergency Medical Service will discuss community preparations to meet a disaster.

A preliminary conference with chairmen of state medical society committees on industrial health will be held on Tuesday, February 23. One of the subjects will cover what American medicine should strive for in its relations with labor and management. Group conferences on subjects related to industrial health also will be held.

In the evening, a dinner will be given in honor of two retiring members of the Council on Industrial Health, Dr. Anthony J. Lanza, New York, chairman, and Dr. Clarence D. Selby, Detroit.

Chicago Medical Society Clinical Conference Scheduled

The annual clinical conference of the Chicago Medical Society is scheduled to be held at the Palmer House, Chicago, March 2 - 5. A faculty of 24 outstanding speakers will present half-hour lectures. Three of these lectures will be devoted to a symposium on hypertension. Another feature will be a clinicopathologic conference.

Other features include daily teaching demonstrations, color television direct from Cook County Hospital, scientific and technical exhibits, etc.

Additional information may be obtained from the Chicago Medical Society, 86 E. Randolph St., Chicago 1, Ill.



Planning To Attend . . .

the 1954 ANNUAL MEETING OF THE OHIO STATE MEDICAL ASSOCIATION in COLUMBUS, APRIL 12-15? If so, better make your HOTEL RESERVATIONS—NOW! Fill out the coupon at the bottom of this page, mail it to the hotel of your choice, and assure your family and self excellent accommodations.

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BEDS
NEIL HOUSE	$5.50-7.00	$8.00-10.00	$10.00-13.00
DESHLER-HILTON HOTEL	$5.00-9.00	$9.00-13.50	$ 9.50-14.50
HOTEL FORT HAYES	$5.50-8.00	$8.50-10.00	$10.00-11.00
SENECA HOTEL	$4.00-6.00	$6.00- 8.00	$ 8.00-10.00
SOUTHERN HOTEL	$5.00-6.00	$6.50- 8.50	$10.00-11.00
HOTEL VIRGINIA	$4.50-5.00	$7.50- 8.00	$ 8.00- 9.00
HOTEL CHITTENDEN	$3.50-4.00	$5.00- 6.75	$ 6.75-10.50

Persons who desire suites or other additional accommodations are advised to specify their needs to the hotel of choice.

(All rates subject to change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 12, 13, 14, 15, 1954, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price .....

☐ Twin Bed Room with Bath ☐ Additional Accommodations (Specify)

Arriving April ..... at ..... A.M. ..... P.M.

PLEASE VERIFY MY RESERVATION

Name .....

Address .....

.....

Physician Members of Family Join in Honor to Dr. Reed



Richland County physicians assembled at the Fairway Club in Mansfield on December 10 to honor Dr. John A. Reed, of Butler, for his 50 years of service in the profession. Surrounded by the physician members of his family, he is shown above (third from left) receiving the State Association's 50-Year Certificate from Dr. John S. Hattery, Councilor of the Eleventh District. Others in the picture, left to right, are his son, Dr. Myron R. Reed; daughters, Dr. Betty Reed and Dr. Barbara Reed; and son-in-law, Dr. Pat Test.

American College of Surgeons Section Meeting Scheduled at French Lick

A program of scientific and economic significance will be offered at the Sectional Meeting of the American College of Surgeons at the French Lick Springs Hotel, French Lick, Ind., March 15-17.

The College's policy of disseminating information about new methods and therapies to improve surgical standards continues as important to the College today as it was back in 1913 when the organization was founded for this purpose. Hence, although this meeting is designed for surgeons, it is open to related fields with no restriction on attendance from outside the area.

Additional information may be obtained from the College, at 40 E. Erie St., Chicago 11, Ill.

International Academy of Proctology To Meet in Chicago

All physicians are invited to attend the Sixth Annual Convention of the International Academy of Proctology to be held at the Palmer House, Chicago, Illinois, April 8, 9, 10 and 11.

Additional information may be obtained from the Executive Office of the International Academy of Proctology, 43-55 Kissena Boulevard, Flushing, New York.

New High School Building Is Named for Late Doctor

"Watkins Memorial" was chosen as the name of the new consolidated high school to be constructed in Licking County to serve the Etna-Kirkersville-Pataskala school district, in memory of the late Dr. C. D. Watkins.

Dr. Watkins served that community for more than a half century before his death in 1942. He started his practice at Kirkersville and later moved to Etna. The name was submitted in a contest sponsored by the local Citizens Committee and selected by the board of education as most suitable.

Dr. Herzberg Returns To Practice in Hillsboro

Dr. Mortimer Herzberg has resumed his practice in Hillsboro on a part-time basis after being hospitalized for nearly three years. In February, 1951, he was twice shot by a crazed patient to whom he had refused narcotics and who killed himself a few moments later.

As the result of the spinal injury, Dr. Herzberg is paralyzed from the waist down and will practice in his office from a wheel chair. He plans to expand his practice as he adapts himself to a special equipped automobile and other aids.

Proceedings of The Council . . .

Hearing Held on Disciplinary Case; Establishment of Committee on Maternal Health Approved; Other Business Transacted on January 16

A MEETING of The Council of the Ohio State Medical Association was held on Saturday, January 16, 1954, starting at 10 a. m., for the purpose of a hearing on the appeal of Dr. Harold J. Wilson, Columbus, from the action and order of the Columbus Academy of Medicine, expelling Dr. Wilson from membership in the Columbus Academy of Medicine.

Dr. Paul A. Davis, president of the Ohio State Medical Association, presided. Other members of The Council present were: Dr. Merrill D. Prugh, Dayton; Dr. H. M. Clodfelter, Columbus; Dr. Richard L. Meiling, Columbus; Dr. George A. Woodhouse, Pleasant Hill; Dr. James R. Jarvis, Van Wert; Dr. Paul F. Orr, Perrysburg; Dr. Charles L. Hudson, Cleveland; Dr. Carl A. Gustafson, Youngstown; Dr. R. J. Foster, New Philadelphia; Dr. Robert S. Martin, Zanesville; Dr. C. L. Pitcher, Portsmouth; Dr. E. H. Artman, Chillicothe.

Dr. Wilson and his attorney, Mr. Robert M. Draper, were in attendance. The Columbus Academy of Medicine was represented by its legal counsel, Mr. William E. Knepper. Also present was Mr. Wayne E. Stichter, Toledo, legal counsel for the Ohio State Medical Association.

CASE TAKEN UNDER ADVISEMENT

Attorneys Draper and Knepper, respectively, presented oral arguments in support of briefs which had been filed. Their statements were recorded for the record by an official court reporter. At the conclusion of the oral presentations, the hearing was adjourned after a statement by President Davis that The Council would carefully study the record of the proceedings and would act at a later date on the matter before it.

Following the hearing, The Council met in regular session for the transaction of certain business.

The first order of business was official approval by The Council of the minutes of the last meetings of The Council, held on December 12 and 13, 1953.

COMMITTEE ON MATERNAL HEALTH

A report of the special committee to study the feasibility of the establishment by the Ohio State Medical Association of a committee on maternal health, one function of which would be to study, analyze and report on all maternal deaths in Ohio, was considered by The Council.

The report, reading as follows, was officially approved by The Council and President Davis instructed to name a Committee on Maternal Health as recommended in the report of the special committee:

"1. On April 23, 1953, the House of Delegates of the Ohio State Medical Association adopted the following resolution:

'Whereas, The medical profession is vitally concerned with maternal health and welfare, and

'Whereas, Improvement in the care of mothers must be based on adequate knowledge of difficulties which arise, and

'Whereas, Knowledge of the causes of maternal deaths is a basic factor in determining what improvement in maternal care is necessary,

'Therefore Be It Resolved, That the Council of the Ohio State Medical Association be directed to appoint a committee, composed of members of the obstetrical and gynecological and general practitioners societies of Ohio and representatives of other interested medical groups, to explore, in cooperation with local boards of health and the Department of Health of the State of Ohio, the feasibility of establishing a Committee on Maternal Deaths, whose function would be to study, analyze and report on all maternal deaths in Ohio.'

"2. Under the provisions of the above resolution, President Paul A. Davis appointed the fol lowing committee:

Anthony Ruppersberg, Jr., 336 E. State St., Columbus, Chairman
Richard D. Bryant, 2500 Melrose Ave., Cincinnati
Herbert D. Chamberlain, Main St., McArthur
Gordon L. Erbaugh, 2156 E. Third St., Dayton
Glen K. Folger, 10515 Carnegie Ave., Cleveland
Richard L. Meiling, 91 N. Columbia Ave., Columbus
Wm. J. Pittenger, 145 Portage Trail, Akron
Herbert W. Salter, 4900 Euclid Ave., Cleveland
Dean E. Sheldon, 408 Columbus St., Sandusky

"3. The chairman discussed this problem, as set forth in the above cited resolution, with individual members of the committee, authorities of the Department of Health, and physicians in other states and towns who are actively engaged in similar studies of this type at the present time.

"4. It was determined that 21 states reported active maternal mortality studies were being conducted on an annual basis in 1951. Eleven additional states planned to start such studies in the near future. In each instance coordination and cooperative liaison was effected between the respective state medical associations and the respective state health agencies.

"5. On January 10 at the Columbus office of the Ohio State Medical Association a meeting was held of the full committee, as well as invited guests, including Dr. John D. Porterfield, Director, Ohio Department of Health, and Dr. Margot D. Hartmann, Chief, Division of Maternal and Child Hygiene. At this meeting a full discussion of the planning, administration, evaluation and reporting of maternal

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health, including maternal mortality studies, was held. The problems associated with the liaison of the Department of Health, as well as with the coroners, the hospital administrators, records, etc., were presented.

"6. Your committee, after full and careful consideration of the mandate presented in the resolution, presents the following recommendations to The Council of the Ohio State Medical Association:

"A. A maternal mortality study for the State of Ohio is feasible and should be sponsored by the Ohio State Medical Association on an annual basis and as a continuous project.

"B. The acknowledged interest of the physicians of Ohio in the problems of maternal health can best be furthered by the establishment of a Committee on Maternal Health.

"C. The members of this Committee on Maternal Health shall be appointed by the president of the Ohio State Medical Association.

"D. A major function of this Committee on Maternal Health shall be to make a study of maternal mortality, as outlined below:

"1. Standards of reporting and nomenclature shall be established in conformity with national and international programs.

"2. Names of patients, hospitals, physicians and others shall not be used in any reports issued by the committee.

"3. Annual reports shall be made to members of the Ohio State Medical Association through *The Ohio State Medical Journal* or in other appropriate ways.

"4. Liaison with the Ohio Department of Health in the maternal mortality study program shall be the responsibility of the chairman of the committee.

"5. Liaison with the Ohio Hospital Association, Ohio Coroners' Association, local public health agencies, Ohio Academy of General Practice, Ohio Section, American Academy of Obstetrics and Gynecology, and local societies of obstetricians and gynecologists, and other agencies or organizations shall be established by the committee.

"6. The committee shall not engage in disciplinary action of any type.

"E. The expenses of the committee shall be borne by the Ohio State Medical Association.

"The committee respectfully submits this report for the consideration of The Council."

BANK RESOLUTION

In order to meet any contingencies which might arise in carrying on the business of the Association due to the death, illness or prolonged absence of the treasurer, The Council adopted a resolution, providing that checks on the Association's checking account may be signed by either the treasurer or the president.

Mr. Stichter reported on the status of the Toledo malpractice case—Evangelista vs. Black. He reported that the motion to certify in this case had been overruled by the Ohio Supreme Court and the case returned to the Common Pleas Court of Lucas County for a retrial. Mr. Stichter advised that there was nothing for the State Association to do in this case at this time.

WORKMEN'S COMPENSATION

The Council was advised that a special committee representing the Association would meet with the Ohio Industrial Commission on January 20 to discuss with the Commission recommendations for changes in the Workmen's Compensation Medical and Surgical Fee Schedule, which had been submitted to the Commission several months ago.

INTERGOVERNMENTAL COMMISSION

A communication from Dr. George F. Lull, Secretary and General Manager of the A. M. A., on the activities of the Commission on Intergovernmental Relations was read and discussed. In his letter Dr. Lull requested the Association to send recommendations as to health activities now supported in part by Federal funds to the American Medical Association which will assemble recommendations from all medical societies and present them to the Commission.

The Executive Secretary was instructed to get in touch with Dr. Lull, asking for suggestions and advice as to the character of information desired; also to suggest to Dr. Lull the possibility of the A. M. A. working out uniform inquiries which could be submitted to state and local medical societies for the securing of helpful information.

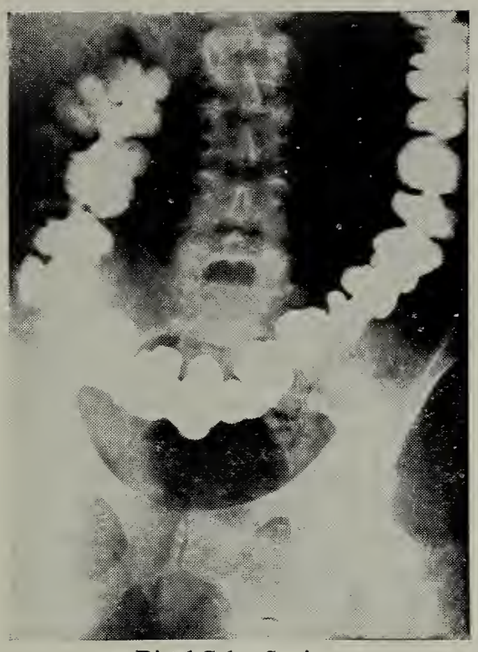
Members of The Council felt that a special committee should be named to assemble information which could be submitted to the A. M. A. if requested by Dr. Lull. On **motion** duly made, seconded and **carried**, the President was authorized to appoint such a committee. The following committee was named by the President: Dr. Richard L. Meiling, Columbus, chairman; Dr. Herbert B. Wright, Cleveland, chairman of the Committee on Public Relations and Economics; Dr. Frank H. Mayfield, Cincinnati, chairman of the Committee on Legislation.

Dr. Arthur D. Collins, Cleveland, chairman of the Subcommittee on Interprofessional Relations on Eye Care, appeared before The Council to secure the opinion of The Council on certain activities which his committee has under consideration.

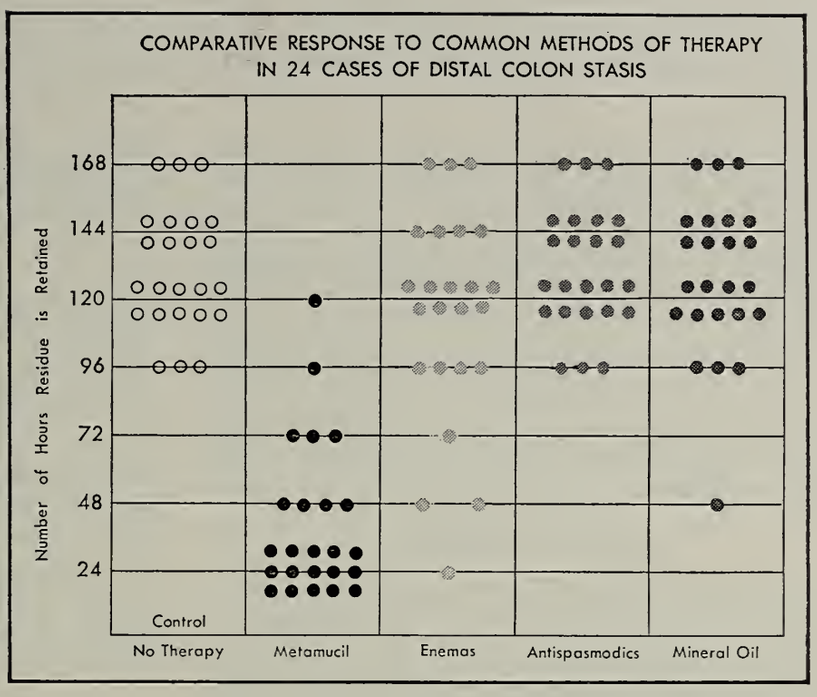
A. M. E. F. PROGRAM

Mr. Saville presented a report on the present status of the American Medical Education Foundation campaign in Ohio. He reported as follows: Ohio doctors' contribution to American Medical Education Foundation in 1953 was practically double the 1952 total. The figures are: 1953—$25,938 from 541 contributors; 1952—$13,-177 from 265 contributors.

A communication from Mrs. N. M. Reiff, Washington Court House, President of the Woman's Auxiliary to the Ohio State Medical Association,



Distal Colon Stasis



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Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It produces smooth fecal bulk necessary to incite the normal peristaltic reflexes, without causing irritation, straining, impaction or interference with the digestion or absorption of vitamins.

The average adult dose is one teaspoonful of Metamucil powder in a glass of cool water, milk or juice, followed by an additional glass of fluid if indicated. This amount of fluid is essential for the production of "smoothage."

It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE *Research in the Service of Medicine*

*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis. Rev. Gastroenterol. *19*:154 (Feb.) 1952.

dated January 14, 1954, was read. Mrs. Reiff asked The Council to act on certain proposed amendments to the By-Laws of the Woman's Auxiliary, which will be presented at the annual meeting of the Auxiliary in April and must be published in the February issue of *The Ohio State Medical Journal*, as required by the By-Laws of the Auxiliary.

By official action, The Council approved the proposed amendments.

The Council then discussed a proposal that the Woman's Auxiliary sponsor a nurse recruitment project to be known as "Miss Student Nurse Contest."

After discussing the proposal quite thoroughly, The Council by unanimous vote disapproved the proposed project and advised the Executive Secretary to communicate the action of The Council to Mrs. Reiff.

LEGISLATIVE MATTERS

A number of items now pending before the Congress were discussed and status reviewed.

By unanimous vote The Council reaffirmed previous action endorsing Senate Joint Resolution No. 1, known as the "Bricker Amendment," and instructed the Executive Secretary to communicate this information to Ohio Congressmen and to issue a legislative bulletin on this subject.

By unanimous vote The Council adopted a motion opposing compulsory old age and survivors insurance coverage for physicians under the Federal Social Security program and instructed the Executive Secretary to convey this information to Ohio's Congressmen and to issue a legislative bulletin covering this action.

HOSPITAL ACCREDITATION

Dr. George A. Woodhouse, chairman of the special Committee on Hospital Accreditation, asked the approval of The Council to send a questionnaire to each County Medical Society asking for specific information as to how the accreditation program is affecting, or has affected, the hospitals of their respective areas. By official action, The Council authorized the committee to prepare and issue such a questionnaire.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.



General Practice Meeting . . .

Outstanding Features Announced for Sixth Annual Assembly of the American Academy of General Practice in Cleveland, March 22-25

FAMILY doctors throughout the country who plan to attend the Sixth Annual Scientific Assembly of the American Academy of General Practice, Monday through Thursday, March 22-25 in Cleveland, will have the opportunity of learning the latest procedures and developments in the field of medicine from thirty-one of the nation's top medical authorities.

FEATURE SPEAKERS

Among the well-known speakers who will address the general practitioners in Cleveland Auditorium are the following:

Sir Alexander Fleming, London, England, discoverer of penicillin, who will appear on the March 24 program presenting, "The Beginning of Antibiotic Therapy," and will also participate in a symposium on antibiotics.

Dr. Edward J. McCormick, Toledo, President of the American Medical Association, will speak on the subject, "The Physician as a Citizen."

Dr. Howard Rusk, New York City, nationally known authority on rehabilitation, will preside over a live clinic on rehabilitation.

Dr. George Crile, Jr., of the Cleveland Clinic, will speak on "The Significance of Thyroid Enlargement."

Dr. George H. Curtis, also of the Cleveland Clinic, will discuss "Allergic Dermatitis."

Dr. Donald M. Glover, Cleveland, director of surgery at St. Luke's Hospital and clinical professor of surgery at Western Reserve, will present an interesting and valuable analysis of "Emergency Room Surgery."

Other well-known physician speakers will include Dr. Clarence S. Livingood, Henry Ford Hospital, Detroit; Dr. Sol Katz, associate editor of *GP*, official publication of the American Academy of General Practice; and Dr. John C. Krantz, Jr., University of Baltimore.

More than forty-five scientific exhibits will supplement the lecture program. Attending physicians will be able to view educational displays such as the "Simplified Approach to Modern Infant Feeding," which will be presented by Drs. Harold Lynch and W. D. Snively of Evansville, Indiana. Academy member Dr. H. B. Chamberlain of McArthur, Ohio, has developed "At Birth Immunizations for Diphtheria, Pertussis, and Tetanus."

The numerous steps in testing and evaluating drugs until they are ready for distribution to the public by physicians will be explained by Dr. Raymond Pogge of Cincinnati in his exhibit, "How a Drug is Born."

The lecture program, arranged by the Academy's Committee on Scientific Assembly under the chairmanship of Dr. John F. Mosher of Coeymans, New York, is designed to give the general practitioner diagnostic techniques and procedures which apply to his everyday practice. Subjects that will be covered include dermatology, gynecology and obstetrics, peptic ulcer, surgery, pulmonary diseases, and rehabilitation.

RECEPTION

Highlighting the social events will be a President's Reception in the ballroom of the Hotel Cleveland March 24, where guests will have an opportunity to greet Sir Alexander and Lady Fleming and other distinguished speakers, as well as national officers of the Academy. Music for dancing will be a feature of the Reception.

Entertainment for the ladies includes a luncheon and fashion show, March 23, in the Rainbow Room of the Carter Hotel, and a "coffee" and book review which will be held in the ballroom of the Statler Hotel, March 24.

Chairman of the Local Arrangements Committee is Dr. Herbert W. Salter, President-Elect of the Ohio Academy of General Practice. Mrs. Salter is in charge of the Ladies' Entertainment Committee.

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recurring office maladies

Suggested Remedy:

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Rural Health Topic of National Conference

The roles of community planning, cooperative efforts, nutrition and insurance in the maintenance of healthful conditions in agricultural areas will be discussed at the ninth annual National Conference on Rural Health in Dallas, Tex., March 4-6.

The conference, sponsored by the American Medical Association's Council on Rural Health, will be held in the Baker Hotel. It will be participated in by physicians and by farm, community and education groups, including agricultural extension workers, from all parts of the country.

Dr. Edward J. McCormick, Toledo, President of the American Medical Association, will be the speaker at the closing session. Also participating in that program will be Dr. Joseph I. Greenwell, New Haven, Ky., who at the Clinical Session of the A. M. A. in St. Louis last December was named as the "General Practitioner of the Year."

Dr. Carll S. Mundy, Toledo, acting chairman of the Council on Rural Health, speaking at the opening session, will sound the conference keynote—"Let's Put More 'U' in CommUNITY."

There will be panels on community programs, nutrition and health insurance. Principal presentations will be made by Mrs. Charlotte R. Bensen, Raleigh, N. C., health education consultant of the Medical Society of North Carolina; Dr. John B. Youmans, Nashville, dean of the Vanderbilt University School of Medicine and member of the A. M. A. Council on Foods and Nutrition, and Lambert Schultz, Chattanooga, staff executive of the group department, Provident Life and Accident Company. J. P. Schmidt, Columbus, professor of rural sociology at the Ohio State University, will be the discussion leader for all three panels, each of which will have three other participants.

State committees on rural health will hold a pre-conference meeting with the A. M. A. Council on Rural Health on Thursday morning, March 4. The topics will include prepaid insurance and the physician's responsibility to his community.

Doctors in AA To Meet in Akron, May 14-16

The Fifth Annual International Group of Doctors in Alcoholic Anonymous will meet at the Mayflower Hotel, Akron, May 14-16.

This group of doctors in AA was formed five years ago with a few men from Western New York State. At last year's meeting there were men present from as far south as Florida and as far west as Colorado.

Additional information may be obtained or reservations made by writing: "Doctors," Mayflower Hotel, Akron, Ohio.

Reprieve Granted Those Who Did Not Pay 1950 A. M. A. Dues

Following is a quotation from the Secretary's Letter of the American Medical Association which will be of interest to physicians who were dropped from A. M. A. membership for failure to pay 1950 A. M. A. dues:

"The A. M. A. House of Delegates, meeting in St. Louis, adopted one resolution, relating to the payment of 1950 membership dues, which may have been overlooked in the rush of business by many medical society secretaries. The resolved portion of the resolution said:

" 'Resolved, that any active member of the American Medical Association who failed to pay dues for the year 1950, and who was suspended for such delinquency, may be reinstated during the first six months of 1954 by payment of 1954 dues only.

" 'Should such an individual fail to pay his 1954 dues by July 1, 1954, he shall continue to be considered delinquent.'

"It is hoped that all county and state society officers will immediately contact any physicians in their organizations who were dropped from A. M. A. membership because of nonpayment of 1950 dues. Such physicians should be acquainted with the provisions of this new resolution, especially with the fact that the waiver will be in effect only to July 1, 1954, and that after that date they again will be liable for payment of the 1950 dues if they wish to be reinstated as members of the A. M. A."

Provisions Are Being Made in Ohio for Transmission of ECG's and EEG's

The Public Utilities Commission of Ohio has authorized the Cincinnati and Suburban Bell Telephone Company and the Ohio Bell Telephone Company to establish rates and regulations for the transmitting and receiving of electrocardiograms and electroencephalograms over telephone wires for an experimental period of one year ending January 31, 1955. Similar authorizations are being requested by telephone companies affiliated with the Bell System throughout the country.

The idea originated in some of the western states, in order to facilitate the furnishing of the advice of specialists to physicians practicing in remote areas. The equipment, developed after much research by medical institutions and the telephone companies, is similar to that used in transmitting news pictures by wire.

Income Tax Deductions . . .

Expenses of Attending Postgraduate Courses, Other Than Residency Work, May Be Deducted, Tax Authorities Say, Under Court Decision

IN filing Federal Income Tax Returns physicians may list as a deduction expenses incurred in attending postgraduate courses as a recent court decision leads tax authorities to believe that such deductions will now be recognized by the Department of Internal Revenue. However, this would not apply, in all probability, to expenses incurred in residency training where a physician is taking special work to qualify himself for a specialty.

The court decision on this subject is final. The Commissioner of Internal Revenue has not as yet issued an order based on the court's interpretation and verdict. However, tax authorities are inclined to the belief that a ruling by the Commissioner permitting approval of deductions for postgraduate expenses will be issued.

This question has been one of long-standing. The American Medical Association has for a period of years endeavored to secure such a ruling. It has participated in court cases on the subject.

The most recent development is well described and analyzed in the following report of the A. M. A. Bureau of Legal Medicine, submitted recently to the House of Delegates of the A. M. A.:

CASE BEFORE THE COURTS

"In the report of the Bureau of last year, reference was made to a pending case involving the right of a lawyer, George G. Coughlin, Esq., to deduct for federal income tax purposes expenses incurred by him in attending a postgraduate course on taxation. In the report it was said that since the issues involved in the Coughlin case were so similar to the right of a physician to deduct postgraduate medical expenses, the Association had decided to enter into the case as amicus curiae. As previously reported, the office of the Commissioner of Internal Revenue denied the right of deduction claimed by Coughlin and the U. S. Tax Court sustained the action taken by the Commissioner of Internal Revenue. The Association filed a brief as amicus curiae before the Tax Court.

"Subsequently the case was appealed to the U. S. Court of Appeals, Second Circuit, and again the Association filed a brief. The case before the appellate court was argued orally on March 11, 1953, and on April 14 the court in a unanimous opinion reversed the decision of the U. S. Tax Court and held that the lawyer could deduct, for federal income tax purposes, the expenses incurred by him in attending the postgraduate course on federal taxation. (Coughlin v. Commissioner of Internal Revenue, 203 F. [2d] 307)

COURSE NECESSARY IN WORK

"In this decision, the U. S. Court of Appeals recited certain facts involved in the case. It reported that the petitioner lawyer, Coughlin, was a member of a law firm practicing in Binghamton, N. Y. This firm was engaged in general practice but did considerable work which required at least one member to be skilled in matters pertaining to federal taxation, and to maintain such skill by keeping informed as to the changes in tax laws and the significance of current court decisions. The partnership relied on Coughlin to keep advised on this subject and in order to do so he attended, during the year in question, an Institute on Federal Taxation which was conducted in New York City under the sponsorship of the Division of General Education of New York University. In so doing, he incurred expenses for tuition, travel, board, and lodging which he claimed as an allowable deduction under the federal income tax laws as ordinary and necessary expenses incurred in carrying on a trade or business.

MORALLY BOUND TO KEEP INFORMED

"The Court of Appeals, in deciding for the petitioner, held that he was morally bound to keep informed on advances that occur in the field of federal tax legislation and that his attendance at the session arranged by the institute was a way well adapted to fulfill his professional duty to keep sharp the tools he actually used in his going trade or business. It may possibly be, the court said, that the knowledge Coughlin thus gained increased his fund of learning in general and in that sense the cost of acquiring it may have been a personal expense. The immediate, over-all professional need to incur the expenses in order to perform his work with due regard to the current status of the law, the court thought, so overshadows the personal aspects that it is the decisive feature.

"Following the decision in the Coughlin case, the Bureau requested tax counsel to express an informal opinion as to the effect of the decision on the right of physicians to deduct expenses incurred in the pursuit of postgraduate medical education. Tax counsel indicated that the decision is of special significance for the medical profession and stated in part:

APPLICATION TO PHYSICIANS

" 'The decision of the Circuit Court is not confined to lawyers. It equally applies to the prac-

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ticing physician who attends postgraduate courses which are similarly designed to refresh his medical knowledge and to keep him informed of recent medical developments. Therefore, in computing his federal income tax a doctor may deduct the expenses of his attendance, namely, the cost of his tuition, travel, board, and lodging.

" 'However, it is by no means clear that the court's decision covers attendance at postgraduate courses which are designed to advance the doctor into a new area of his profession. For example, there is a good deal of doubt whether a general practitioner may deduct his expenses in attending a postgraduate course in order to specialize in surgery. But this would be the unusual case. Normally, a doctor attends a postgraduate course relevant to the field in which he is practicing and all the expenses which he so incurs are deductible by him.'

"The government did not appeal from the decision in the Coughlin case and the time within which such an appeal could have been perfected has expired."

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Federal Trade Commission has taken action against an Ohio firm engaged in sale of health books, devices, foods and drugs. An order issued by FTC against Natural Foods Institute, of Olmsted Falls, prohibits further advertising claims that: Cancer can be relieved or cured by treatment described in a book, "The Grape Cure"; Dr. Gaymont's Yogourt Culture is useful against ulcers; arthritics, diabetics and asthma sufferers will benefit by following recommendations presented in book called "Raw Vegetable Juices"; use of a device known as "Vita-Mix" will improve eyesight or benefit teeth, and another gadget ("Juicex") will assure health and vigor. F. T. C. also ordered the company to drop "Institute" from its trade name.

* * *

Federal Trade Commission has filed a complaint against Chicago Invisible Contact Lens Service, charging exaggerated claims for its product.

* * *

Senator Irving Ives (R., N. Y.) has filed a bill to authorize commissioning of males in the nurse corps of the armed services.

* * *

Dr. Arden Freer, retired assistant chief medical director of the Veterans Administration, will be named as a special consultant to the Hoover Commission's medical task force.

* * *

Washington regional office of World Health Organization reports effective application in Egypt of electro-coagulation method of treating trachoma.

* * *

Federal Trade Commission has launched a nation-wide investigation of objectionable and deceptive advertising in the field of hospitalization and medical care insurance.

Vocational Rehabilitation Director of Department of Health, Education and Welfare says that for third successive year the state-federal rehabilitation program has enabled more than 60,000 physically handicapped persons to become self-supporting.

* * *

For home-town fee basis medical care, the budget bureau has released two million of the $2,783,000 in Veterans Administration funds which it impounded last year for economy purposes.

* * *

Incidence of infectious hepatitis reached approximately 33,000 cases in 1953, but much of the 100 per cent gain over 1952 has been ascribed to better reporting.

* * *

I. S. Falk, since 1940 the chief of research and statistics in the Federal Security Agency and one of the framers of social security, is on leave of absence from that position and will not return. His position will be taken over by Wilbur J. Cohen, who will step down from his position as technical advisor to the Commissioner of Social Security.

* * *

Advertised therapeutic claims for the "Barca Lounger" chair are to be discontinued by stipulation between its manufacturer and the Federal Trade Commission.

* * *

Release into commercial channels of blood volume expander PVP (polyvinylpyrrolidone) is now up to the Food and Drug Administration. Up to this time it has been used exclusively for civil defense and emergency stockpiling. Chief suppliers are Schenley, Abbott and General Aniline.

a good "mixer"

for your cough prescriptions

especially valuable when allergic factor

is suspected or present

Chlor-Trimeton syrup q.s. ad

• taste appeals to young and old

• compatible with commonly prescribed medications

Contains CHLOR-*TRIMETON*® Maleate

(brand of chlorprophenpyridamine maleate), 2 mg. per teaspoonful (4 cc.).

Schering

CHLOR-TRIMETON SYRUP

SCHERING

You and Your Public . . .

Here Is One Physician Who Believes That a Frank Discussion of Fees Makes for Better Patient Understanding and Does Something About It

DR. W. L. PORTTEUS, Franklin, Indiana, president-elect of the Indiana State Medical Association, gives to all his patients a small six-page folder which contains a frank explanation of services and fees.

The cover page of the folder contains the same message that is carried on the American Medical Association plaque, inviting patients to discuss these matters! It reads:

To All My Patients . . .

I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between physician and patient.

The text of the remaining five pages of Dr. Portteus' pamphlet follows:

As Your Physician—I believe the misunderstandings about the payment of medical bills can be avoided if fees and services are discussed in advance.

It is always my intent to explain fully to each patient—but there may be occasions when I may not fully anticipate the questions which may be foremost in your mind. I hope this pamphlet will assist you in having a better understanding of my services and fees.

If There is Doubt—in any manner in your mind about the charges for your care, please ask me. We will both benefit by a frank discussion, and I want you to feel free to discuss your financial situation with me, if such is your desire.

My Fees are Based—not only on the time spent with you and the nature of your illness, but also upon the time which will be required in making the necessary arrangements for your surgery, and the care required until you are again well and feeling like yourself.

So You May Understand—better the cost of your care, and know of the many details involved in preparing for and providing the best care, I ask that you read carefully the following. If you have any questions after you read this pamphlet—please remember, I want you to ask me so a complete understanding may be had.

Your Care Will Require the Services of a Team—Surgical treatment requires the services of a team of highly trained specialists—all skilled in their particular responsibility. Not only will I, as your physician, be in attendance, but also a surgeon, an anesthetist, several nurses and in some cases an assisting surgeon.

Costs vs. Security—For your security many examinations and tests will be made. Guess work has been removed in giving you the best medical care in the world today. Laboratory tests and x-rays may be needed to determine the reactions of your body and in helping to establish a diagnosis. Also, in case extra blood is required, this too, will be on hand for immediate use and many other security measures which you may not see—for these, there will be charges.

Your Bill—will in most cases be rendered by the individual members of the team. We shall try and explain as follows—

The Hospital—will bill you for the services furnished by the hospital. These usually include your room, board, nursing care, laboratory tests, x-ray, use of operating room (which includes payment for the sterilization both prior and following your surgery, of the room, garments, uniforms, linens, instruments, etc.). They will usually bill you for oxygen, drugs and other hospital services administered while you are a patient. (The number of laboratory tests and



x-rays will vary according to the type of case and unforeseen complications and usually it is not possible to give you an exact estimate on these items.)

Your Surgeon—who is highly skilled and well-trained, and who will be in charge of your surgery will bill you for his services.

The Anesthetist—who has had special training in administering the many modern anesthetics, will charge for his services. The charge which will be shown on your hospital bill for anesthesia is for the materials used and appliances furnished by the hospital and does not include the physician's fee.

The Assisting Physician—In most cases of surgery an assisting physician or surgeon is required. While this may seem unnecessary, and added expense—it is for your protection. Added, skilled assistance, makes for speedier and safer surgery. You will be billed for this service.

Your Insurance Plan—If you have a hospital

LONG BEFORE HOT FLUSHES APPEAR . . .

Patients presenting such classic menopausal symptoms as hot flushes cause little diagnostic difficulty. However, throughout the period of declining ovarian function which may begin long before hot flushes appear, many women complain of distressing symptoms which though less clearly defined are actually due to estrogen deficiency. For example, insomnia, headache, easy fatigability, and symptoms affecting the bones, joints, and the skin may not be readily identified as due to estrogen deficiency because they may occur years before, or even years after cessation of menstruation.

Investigators[1,2] have found that as the body attempts to adjust itself to declining estrogen production, a number of symptoms may appear which call for the prompt institution of estrogen replacement therapy. These symptoms may be nervous, circulatory, arthralgic, or dermatologic in character because the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism"[3] and affects many body functions. If such metabolic imbalance or deficiency is evidenced, the administration of estrogen is clearly indicated.

"PREMARIN" presents the complete equine estrogen-complex as it naturally occurs. "Premarin" not only produces prompt symptomatic relief, but it also imparts a gratifying and distinctive "sense of well-being." It has no odor . . . imparts no odor.

"PREMARIN" ®

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Estrogenic substances (water-soluble), also known as conjugated estrogens (equine). Available in both tablet and liquid form.

1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

Ayerst

NEW YORK, N. Y. • MONTREAL, CANADA

5405

and surgical insurance plan it should be carefully studied in order that you will know in advance how much of your total bill your insurance will cover. I will be glad to help you prepare an estimate of your total charges as well as how much of these charges your insurance will provide for. I would suggest that you bring your policy with you for this discussion.

Your Family Physician—As your family physician my charges will include: my services rendered prior to your entering the hospital; the calls I will make on you while you are hospitalized, which may be only one or several in a twenty-four hour period; the time and expense of making arrangements for your surgery and hospital admission and for the care required in your illness until you are enjoying a good recovery.

I may be the anesthetist or the assisting physician during your surgery.

It is Difficult—to explain every move and every service which is necessary to provide this care for you and keep it in brief form. I hope you will find this helpful in giving you a better understanding of the services which you will receive and the charges for these services.

Again, I invite you to discuss these matters with me, frankly, as it is my desire that you have complete information and understand fully all details in our caring for you.

Sincerely,

W. L. Portteus, M.D.

Conference on "Aging" . . .

State-Wide Meeting at Ohio State University Will Have Many Facets Of Interest to Physicians; Ohio Citizens' Council Is Joint Sponsor

REPRESENTATIVES of the Ohio State Medical Association are participating in the planning for a state-wide conference on "Problems of the Aging," jointly sponsored by Ohio State University and the Ohio Citizens' Council for Health and Welfare and which will be held March 23-24 on the university campus.

Dr. Howard L. Bevis, president of the University, will serve as general chairman of the conference and Dr. Bland L. Stradley, university vice-president, will serve as vice-chairman.

Purpose of the conference will be (1) to inform Ohioans on what the major problems are and what practical steps already are being taken toward meeting some of them; (2) to provide opportunity for discussion of concrete ways of effectively coping with the remaining ones.

TOPICS SCHEDULED

Major conference topics will include:

1. Employment and retirement problems of older persons, such as employment opportunities, retirement policies, pre-retirement counseling, and public and private pension plans.
2. Health problems of an aging population in the areas of mental health, chronic illness, and rehabilitation.
3. Housing needs of aged persons, such as institutional facilities, rest homes, and group living arrangements.
4. Recreation and leisure-time activities and educational opportunities for the aged.
5. Social services for older people.
6. Community responsibility in meeting these problems.

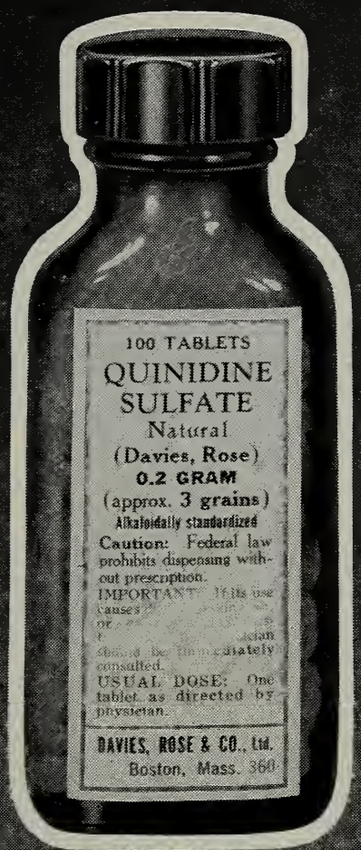
"The number of persons 65 years old and older in Ohio's population has increased more than 30 per cent since 1940, while the over-all population has increased only slightly over 15 per cent," Dr. George T. Harding of Worthington, Ohio Citizens' Council president, said. "This is somewhat typical of the change in the nation's population. The increasing per cent of older persons in our population presents many new economic and social problems which will become increasingly serious unless leaders in all walks of life become interested in their solution now. This Ohio Conference on Problems of the Aging is evidence of such interest in our state."

The Ohio Citizens Council is financed largely through Community Chests and United Appeals of more than 40 Ohio cities. It has functioned for many years as a state-wide research, planning and coordinating agency in the broad fields of health, welfare and recreation.

Details of the program are now being drafted. There will be general sessions and section meetings for discussion of the topics outlined above.

The conference will be open to all persons interested in the problems of aged persons, especially those belonging to groups, organizations and agencies endeavoring to find answers to such problems.

As soon as program details have been completed, representatives of the medical profession in all parts of the state will be invited to attend and take part in the informal discussions which will be carried on, supplementing the organized panel discussions which will be arranged.



OF SPECIAL SIGNIFICANCE TO THE CARDIOLOGIST

Who knows that when he specifies

TABLETS QUINIDINE SULFATE (Davies, Rose) 0.2 Gram (approx. 3 grains)

he is prescribing Quinidine Sulfate, produced from NATURAL sources, in an alkaloidally standardized unit of unvarying activity and quality.

Davies, Rose & Company, Limited **Boston 18**

Q-3

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

FINANCIAL INTEREST BY PHYSICIAN IN PHARMACY RULED UNETHICAL

From time to time the Columbus Office receives a letter from some member or, even, a county medical society, asking whether physicians should, or should not, hold a financial interest in a pharmacy.

That question was answered head-on by the Judicial Council of the American Medical Association recently. In its report to the A. M. A. House of Delegates at the St. Louis session in December, 1953, the Judicial Council issued the following statement of policy which was approved by the House of Delegates:

"The Council has had many inquiries regarding the ownership of pharmacies by physicians. The Principles of Medical Ethics are very clear in regard to this matter. Section 6, Chapter 1, of the Principles provides that "An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient."

"The Council has ruled that it is unethical for a physician to have a financial interest in a pharmacy in the area in which he conducts his professional activities and where he profits directly or indirectly from the sale of devices or remedies prescribed for his patients. This is particularly true when the services of other reputable pharmacies are readily available.

"Along with the problem of ownership of pharmacies by doctors may be considered the question of rental of space to a pharmacist in a clinic or office building owned or leased by physicians. When physicians rent such a space on a sliding scale or for a percentage of the income received by the pharmacy the result is equivalent to receiving a rebate from the prescription and is therefore unethical."

WRITE YOUR CONGRESSMAN ABOUT THESE MEASURES—NOW

If you have not done so, better write your Congressman and express your views on several pieces of proposed legislation now under consideration by the Congress, which convened on January 6.

For example, ask him to support the Jenkins-Keogh Bills (H. R. 10 and H. R. 11) **if you subscribe to the principles and provisions of those measures,** the essence of which is summarized below.

For example, ask him to oppose compulsory coverage of physicians and certain other self-employed persons under the Old Age and Survivors Insurance title of the Social Security Act **if you oppose compulsory coverage for yourself and others in your category.** This is discussed below, also.

Facts on the Jenkins-Keogh Bills and the Social Security question are covered in action of the House of Delegates of the A. M. A. at the recent St. Louis session. Here is a report of the Reference Committee on Legislation and Public Relations which was approved by the House of Delegates:

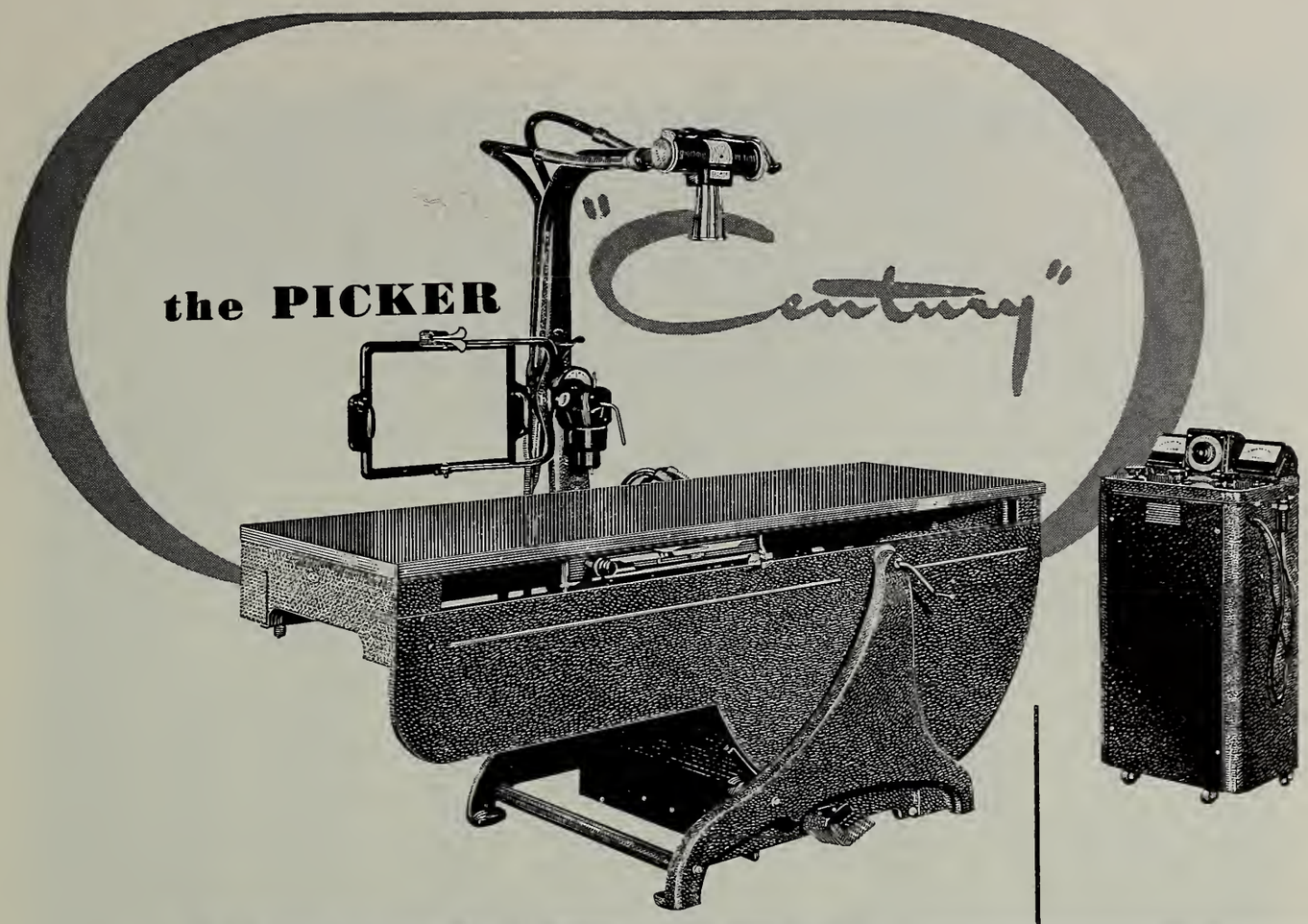
"Resolution on Social Security and Report of Committee on Legislation on Jenkins-Keogh Bills (H. R. 10 and H. R. 11): Your committee carefully considered resolution No. 10 on the subject of social security, introduced by Dr. Willard A. Wright, North Dakota, and the Report of the Committee on Legislation of the Board of Trustees on the Jenkins-Keogh bills. The purpose of these bills is to eliminate the discrimination and inequities which exist under present tax laws by extending the tax deferment privilege to the country's 10 million self-employed and also to millions of employees who are not covered by pension plans. The purpose of the resolution is to reaffirm our support of the voluntary pension program provided in the Jenkins-Keogh bills and to reaffirm our strong opposition to the extension of compulsory coverage of physicians and other self-employed persons under Title II of the Social Security Act. Your committee recommends the adoption of the resolution."

WANTED: MORE DOCTORS WHO READ IMPORTANT LETTERS

A New England physician, just for the fun of it and out of curiosity, kept track of the direct mail advertising he received during the period May 1, 1952, to April 30, 1953. He received 3305 pieces. Here's one reason why doctors don't read all their mail.

Which causes us to recommend that Ohio physicians should not be too hasty in kicking into the waste basket, mail received from the Ohio State Medical Association. It doesn't send out throw-away stuff. The only way for Ohio doctors to keep up on what's cooking in Ohio is by reading *The Journal* and the *OSMAgram.* They carry, also, plenty of news on what's going on on the national scene. A letter from the Columbus Office should not be ignored or allowed to accumulate dust. It may be the most important piece of mail delivered that day.

This may sound rather screwy to you, Doctor,



it's so *easy to use* . . . the automatic "Century" Control *really* monitors operation; relieves you of technical worries.

it's so *dependable* . . . identical "Century" settings produce identical results time after time — yesterday, today, tomorrow.

it's so *trouble-free* . . . "Century" stamina has been amply proven in the experience of thousands and thousands of users the world over.

it's so *handsome* . . . looks as distinguished as it is. Owners are *proud* of their "Centurys".

Definitely the *fine* x-ray unit in the moderate price class . . . and so widely esteemed that there are more Picker "Century" 100 ma units actively in use than any other similar apparatus.

Picker x-ray

PICKER X-RAY CORPORATION
25 So. Broadway • White Plains, N. Y.

CLEVELAND 6, OHIO, 2126 E. 107th Street
CINCINNATI 11, OHIO, 4271 Harrison Avenue
COLUMBUS 1, OHIO, 1202 Forsythe Avenue

TOLEDO 7, OHIO, 844 Sawyer Road
NO. CANTON, OHIO, Rd. #2 Wise Road

but you'd be surprised to know how many physicians don't read even important mail. Of course, it's the other fellow, not you, so skip it.

EACH PHYSICIAN SHOULD RENDER HIS OWN BILL

Apparently some Ohio physicians do not have a factual understanding as to whether it is considered ethical and appropriate for an attending physician to include with his own bills to a patient, bills for services rendered by physicians who may have assisted, or anesthetists, even though the statement rendered is itemized as to the name of the assistant or anesthetist and the charge for his services.

Several inquiries on this question have been received at the Columbus Office. The answer is clear and definite. Here are the facts:

At the recent St. Louis meeting of the House of Delegates of the American Medical Association, a delegate presented a resolution dealing with fees, collections, statements, etc. One resolve advocated the policy of joint billing and the distribution of the fees listed by the physician receiving the check for the total, if one check is received in payment.

The Reference Committee to which this resolution was referred said in its report which was approved, that the "committee feels that it is unable to render a decision because the final interpretation of ethics is within the province of the Judicial Council."

However, the Reference Committee made the following additional statements, which reveal that under the existing policy of the A. M. A. based on an interpretation of the Judicial Council, joint billing is considered unethical and improper:

"We note in the minutes of the House of Delegates at its December, 1952, meeting in Denver that the Judicial Council rendered an opinion on an almost identical question. On page 1706 of *The Journal* in the Dec. 27, 1952, issue is found this statement: 'When a surgeon renders his bill for his fee, it should not include bills from colleagues who act as assistants or anesthetists, but these colleagues should render their own bills.'

"Your committee recommends that these resolutions be referred to the Judicial Council requesting that the Council investigate the factors involved in the matters as presented and determine if there are new factors or new facets that would cause it to change the opinion of 1952 quoted above. In addition we recommend that the Judicial Council be specifically requested to report on this request at the June 1954 annual meeting. We further recommend that this action be approved by the House of Delegates."

Therefore, until and unless a new policy is formulated by the House of Delegates of the A. M. A. or a revised interpretation is made by the Judicial Council, joint billing is regarded as a violation of the Principles of Medical Ethics.

Proposed Changes in By-Laws of Woman's Auxiliary

Several proposed amendments to the By-Laws of the Woman's Auxiliary to the Ohio State Medical Association will be presented, for action, to the House of Delegates of the Auxiliary at its 1954 Annual Meeting in Columbus next April.

The proposed amendments were approved by The Council of the Ohio State Medical Association on January 16, as required under the By-Laws of the Auxiliary, and they are published herewith in *The Journal* as required by the By-Laws:

CHAPTER 4

House of Delegates

In Sec. 4, Committees, delete the words, "Nominating Committee."

Substitute a new Sec. 5, Nominating Committee, reading as follows: "On the first day of the Annual Convention, the House of Delegates shall elect a Nominating Committee of seven members, two of whom shall be from the Board of Directors and five from the body of the House of Delegates. The election shall be by ballot and the Board member receiving the highest number of votes shall serve as chairman of said committee. At the same meeting the convention shall elect one from the Board of Directors and three from the House of Delegates as alternate Nominating Committee members."

Renumber old Sections 5, 6 and 7 as Sections 6, 7 and 8, respectively.

CHAPTER 6

Duties of Officers

Add a new section to be known as Sec. 10, reading as follows: "The treasurer, Recording-Secretary, and the Historian shall continue to function for one month after the Annual Meeting to complete their year's work. An interim audit shall be made at the same time for the protection of the incoming Treasurer."

4-H Club Winners Get "Today's Health"

Inaugurating a new project in its rural health education program, the Wisconsin State Medical Society decided in November to give one-year gift subscriptions to *Today's Health* magazine to all 4-H Club achievement winners throughout the state.

In announcing the gift, the Society urged each of the 40 winners to circulate the magazine to other club members. For many years, the Society has given engraved certificates to these winners but this time felt that a subscription was a much more practical gift. Other medical societies might well follow Wisconsin's example.



Cost of therapy with HYDROCORTONE is now substantially the same as with cortisone.

Offers significant advantages in treating rheumatoid arthritis

Hydrocortone®

(HYDROCORTISONE, MERCK)

HYDROCORTONE possesses greater anti-rheumatic activity and is reported to be better tolerated than cortisone. Reports emphasize that hydrocortisone has produced clinical improvement faster than cortisone and with smaller doses. In several cases, endocrine disturbances encountered during cortisone therapy have been reported to disappear or diminish when the smaller but equally effective doses of hydrocortisone were substituted. Boland, E. W. and Headley, N. E., *J.A.M.A.* **148**:981, March 22, 1952.

SUPPLIED: ORAL—HYDROCORTONE Tablets: 20 mg., bottles of 25 tablets; 10 mg., bottles of 50 tablets; 5 mg., bottles of 50 tablets.

ALL HYDROCORTONE Tablets are oval-shaped and carry this trade-mark: 

Ethical or Unethical? . . .

Actions by A. M. A. House of Delegates Leave No Uncertainty About Principles Governing Physicians in Relationships With Other Groups

IN its August, 1953, issue, *The Ohio State Medical Journal* published a statement of policy on physician-hospital relations, subscribed to by the House of Delegates of the American Medical Association and the House of Delegates of the American Hospital Association.

One of the basic principles enumerated in that statement read as follows:

> **"The right of an individual to develop the terms of his services on the basis of local conditions and needs is recognized, but such contractual arrangements should in all cases ensure (a) the policy of professional incentive for the physician, and (b) progressive development of the hospital departments involved, in order that increasingly improved services to patients may be rendered.**
>
> **"Moreover, a physician shall not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the patient, the hospital, or the physician."**

NEED FOR CLARIFICATION

Judging from discussions which took place at the recent session of the A.M.A. at St. Louis and resolutions presented to the House of Delegates, the principles stated above, and others which appeared in the "Guides for Conduct of Physicians in Relationships with Institutions," adopted by the A.M.A. in December, 1951, have in some instances been misunderstood and in others, misinterpreted.

Actions of the A.M.A. House of Delegates at St. Louis, left no doubt as to the meaning of these principles and clearly point out how and why they should be observed and enforced.

STATEMENT OF JUDICIAL COUNCIL

In the report of the Judicial Council of the A.M.A. which received the endorsement of the Reference Committee on Miscellaneous Business and was approved by vote of the House of Delegates, the following statements regarding physician-hospital relationships, employment of physicians by hospitals, and codes of ethics, were made:

THE PURVEYAL OF MEDICAL SERVICES

"There have been many inquiries regarding the employment of physicians by hospitals. Most of them pertain to practices of anesthesiologists, radiologists, pathologists, and physiatrists.

"The Council has repeatedly stated that the acceptance of a salary by a physician does not of itself constitute unethical conduct. This opinion is predicated on the Council's interpretation of the Principles of Medical Ethics, particularly Section 6, Article VI, Chapter III entitled, 'Purveyal of Medical Services.' It is the opinion of the Council that this section is a clear, unambiguous enunciation of a principle, and that any uncertainty associated with the principle stems from failure to understand and appreciate that it must be applied to a specific factual situation.

"The issue to be resolved then is factual. If, in a given situation, a physician disposes of his professional services under terms which permit exploitation, his conduct is unethical. Knowledge of the facts, however, may reveal that there is not exploitation; that there is not an unethical division of fees; that there is not a denial of free choice of physician as defined by the Principles or that the arrangement does not cause a deterioration of the quality of medical services.

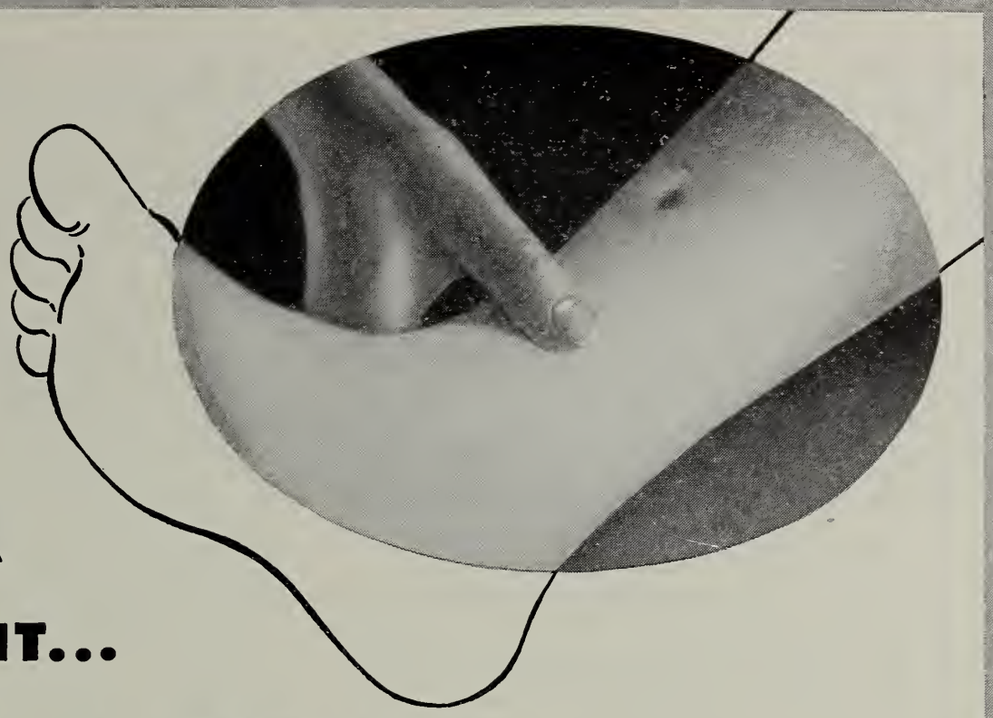
"The Judicial Council believes that the 'Relation of Physicians and Hospitals' (Guides for Conduct of Physicians in Relationships with Institutions) and the 'Report of the Joint Committee on Hospital-Physician Relationships of the Boards of Trustees of the American Medical Association and American Hospital Association' make it abundantly clear that when such questions arise their solution depends on an analysis of the factual situation which obtains in each relationship. Each of these reports reaffirms in its own language existing ethical principles. Each suggests that solutions of controversies relating to financial arrangements can best be effected at the local level. Each emphasizes that the question of ethics involved in establishing terms by which a physician may dispose of his professional attainments or services depends on whether they are exploited and whether any other principle of ethics is involved.

ACCEPTANCE OF COUNCIL RULINGS

"The Principles of Medical Ethics of the American Medical Association provides the basis on which are predicated all principles of medical ethics, which are utilized to guide the activities of physicians. The fact that a physician is a member of a specialty group or of a constituent association where special interpretation of ethical principles has been provided does not release him from his obligation to comply with the Principles of Medical Ethics of the American Medical Association. When classified special societies request a ruling of the Council on behalf of their membership on the Principles of Medical Ethics, it is the duty of the membership of that particular society to accept the ruling of the Judicial Council of the American Medical Association as final.

PRINCIPLES OF MEDICAL ETHICS MAY BE AMENDED ONLY BY VOTE OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

"There have been instances in which a state association or a specialty organization has announced an interpretation of a segment of the Principles of Medical Ethics which is definitely



TO DRAIN THE EDEMA PATIENT...

Effectively • Conveniently...

Solution · Tablets

SALYRGAN®-Theophylline

MERCURIAL-XANTHINE DIURETIC

FOR EDEMA due to cardiovascular and renal insufficiency, as well as hepatic cirrhosis

By a dual action on the kidneys which both increases the volume of the glomerular filtrate and diminishes tubular resorption, Salyrgan-Theophylline rapidly produces copious diuresis.

The response to Salyrgan-Theophylline solution does not "wear out" so that doses may usually be repeated as required, without loss of efficiency.

With Salyrgan-Theophylline tablets taken orally, patients appreciate the gradual, non-flooding diuresis and the greater convenience. Salyrgan-Theophylline tablets "can successfully decrease the patient's burden... either by decreasing the need for frequent mercurial injections or by actually replacing the injections entirely."[1]

WINTHROP

1. Abramson, Julius, Bresnick, Elliott, and Sapienza, P. L.: *New England Jour. Med.*, 243:44, July 13, 1950.

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contrary to that adopted by the American Medical Association. The Judicial Council wishes to emphasize that the only method by which the Principles of Medical Ethics of the American Medical Association may be altered requires the formal presentation of a resolution to the House of Delegates of the American Medical Association embodying an amendment to the Principles of Medical Ethics. When the proposed revisions are properly presented, they will receive appropriate consideration and when reported by the reference committee will be subject to discussion and vote by the House of Delegates. They may, however, be referred to the Council on Constitution and By-Laws. The adoption and broadcasting of so-called principles of medical ethics by any other process by any other society or organization is to be condemned."

ADDITIONAL ACTION BY DELEGATES

Several resolutions asking for clarification of the previous policy of the A.M.A. on this subject were considered by the Reference Committee on Miscellaneous Business. The reference committee pointed out that all of the resolutions have to do with the same subject. It submitted a substitute resolution, reading as follows, which was approved by vote of the House of Delegates:

> **"Resolved, That in the relations of physicians and hospitals, the 'Guides for Conduct of Physicians in Relationships with Institutions,' as published by the American Medical Association in December, 1951, be strictly followed."**

In addition to the foregoing, publication has been given to a letter, dated September 22, 1953, signed by Edward R. Cunniffe, M.D., chairman, Judicial Council of the A.M.A., and addressed to the director of a hospital in New England, amplifying the statements made in the report of the Judicial Council at the St. Louis session. Dr. Cunniffe's communication, reading as follows, clearly and decisively summarizes all phases of the question:

DR. CUNNIFFE'S LETTER

"You have asked the Judicial Council if a doctor who is employed on a salary basis by a hospital is guilty of unethical practice.

"When called upon to answer an inquiry concerning matters of ethics, the Judicial Council of the American Medical Association is bound by the Principles of Medical Ethics, the Constitution and By-Laws of the American Medical Association as they stand adopted by the House of Delegates of the Association. The jurisdiction of the Judicial Council does not extend beyond the consideration of these three documents.

"In the past, the Council has repeatedly stated its opinion that the acceptance of a salary by a physician does not necessarily constitute unethical conduct. This opinion is predicated on the Council's interpretation of the Principles of Medical Ethics, particularly Section 6, Article VI, Chapter III entitled, 'Purveyal of Medical Services.' It has been and is the opinion of the Council that this Section is a clear, unambiguous enunciation of a principle and that any uncertainty associated with the principle stems from failure to understand and appreciate that the principle must be applied to a specific factual situation.

"The principle is clear. The issue to be resolved then is factual. What are the facts? If in a given situation a doctor disposes of his professional attainments or services under terms which permit exploitation of those attainments or services by a hospital, etc., then he violates a principle of medical ethics. Can it be stated categorically that a salary is a 'term' which permits such exploitation? The Judicial Council does not believe that a financial arrangement, whether by salary or otherwise, between a physician and a hospital, etc., can be appraised or evaluated and found to be ethical or unethical until all the facts are established. To know the facts is to know that there is or is not permitted an exploitation of the services of a physician; that there is or is not a denial of free choice of physician as defined by the Principles; that the arrangement causes or does not cause deterioration of the quality of medical services rendered.

"The Judicial Council believes that the 'Relation of Physicians and Hospitals' (Guides for Conduct of Physicians in Relationships with institutions) and the 'Report of the Joint Committee on Hospital-Physician Relationships of the Boards of Trustees of the American Medical Association and American Hospital Association' make it abundantly clear that questions which arise under Section 6, Article VI, Chapter III of the Principles of Medical Ethics depend for their solution upon an analysis of the factual situation which obtains in each relationship. The first named report suggests principles to adjust controversies. The latter recommends principles to accomplish the objectives enunciated in both reports. Each report in its own language reaffirms existing ethical principles. Each suggests that solutions to controversies relating to financial arrangements can best be effected at local level. Each emphasizes that the question of ethics involved in establishing terms by which a physician disposes of his professional attainments or services depends upon whether these attainments or services are in fact exploited and whether any other principle of ethics is involved.

"To recapitulate, it is the opinion of the Judicial Council that it is neither the sense nor the intent of Section 6, Article VI, Chapter III of the Principles of Medical Ethics to establish as ethical or to proscribe as unethical any particular financial arrangement—any term or condition—by which a physician disposes of his professional attainments or services. It is further the opinion of the Council that Section 6, recognizing the nature and the essence of the practice of medicine, proscribes not one, not the most flagrant, but every act which permits the professional attainment and services of a physician to be exploited for the financial profit of any agency—for all such acts are detrimental to the welfare of the patient and the good of the profession."

Top Organizations Sponsor Conference On Trichinosis in Chicago

The American Medical Association is joining a dozen or more other national organizations interested in health in sponsoring the Second National Conference on Trichinosis at the A. M. A. Headquarters, Chicago, on Monday, March 1. A reception will be held at the Drake Hotel.

Additional information may be obtained from the American Medical Association.

Civil Defense-Red Cross Agreement . . .

Organizations Get Together on Respective Areas of Responsibility In Case of Disaster Either from Enemy Action or Natural Causes

A STATEMENT of understanding between the Ohio Civil Defense Corps and the American National Red Cross delineating and defining the various areas of responsibility of the two organizations in event of enemy-caused or natural disaster will be of interest to physicians who are directly or indirectly concerned with Civil Defense activities or programs of the Red Cross in their respective communities.

The agreement, recently signed by Governor Frank J. Lausche and Maj. Gen. Albert E. Henderson, director of the Ohio State Civil Defense Corps, and Harold B. Nearman, manager, Eastern Area, American National Red Cross, reads as follows:

1. **Disasters Resulting from Enemy Action:**

   A. Civil Defense is fully responsible.

   B. Civil Defense will utilize all community agencies, including Red Cross in carrying out this responsibility.

   C. Civil Defense will assume financial responsibility and will operate in accordance with existing Civil Defense policy and procedure.

2. **Disasters Resulting from Natural Causes:**

   A. The American National Red Cross will carry out its traditional services to those in need as a result of disaster by providing among other things such assistance as food, clothing, shelter, medical care, household furnishings, building and repair of homes and occupational rehabilitation. The Red Cross in carrying out its relief program, will exercise administrative and financial control over its own operations.

   B. If a natural disaster is declared an emergency by the Governor of the State of Ohio or the head of any political subdivision of the State, and providing the governmental responsibilities are delegated to the Civil Defense organization, the various activities of the emergency will be supervised and coordinated by Civil Defense. The American Red Cross, under such conditions, will assume its traditional responsibilities in cooperation with Civil Defense authorities as outlined under 2-A above.

Reference is made to FCDA Advisory Bulletin No. 138, which states, "Federal funds authorized under Public Law 875 will not be used to reimburse States and localities for expenditures made by them within the area of Red Cross disaster responsibilities."

3. Liaison

There are arrangements for national, regional and State liaison, mutual planning and exchange of information regarding disasters between the American National Red Cross, the Federal Civil Defense Administration and the Ohio Civil Defense Corps. It is imperative, also, that there be established continuous liaison between Civil Defense and Red Cross in every community. Civil Defense representatives should be assigned to local Red Cross disaster committees, and Red Cross liaison representatives should be assigned to Civil Defense staffs.

General Henderson in attesting the written statement commented that "each organization has an important part to play in combating the effects of any serious disaster, whatever its nature, that neither organization can function with maximum effect without support from, and liaison with the other."

He further observed: "This definite 'understanding' between the Ohio Civil Defense Corps and the American National Red Cross will serve as a foundation upon which local chapters of the Red Cross and local Civil Defense Directors can work out mutually satisfactory welfare and assistance programs assuring full cooperation between the two important organizations in any future major disasters."

New Members of O. S. M. A.

The following are the names of new members of the Ohio State Medical Association since December 7, 1953. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY

Cooke, Robert F., Cleveland
Edgecombe, Percy W., Cleveland
Epstein, Lloyd S., Cleveland
Erlandson, Marion E., Cleveland
Regan, Audrey G., Cleveland
Tolan, Eliere J., Macedonia
Weiss, Herbert J., Cleveland

FRANKLIN COUNTY

Leist, John W., Columbus
Retter, Richard H., Columbus

JEFFERSON COUNTY

Campbell, William H., Toronto

MAHONING COUNTY

Gordon, James N., Struthers

RICHLAND COUNTY

Dozier, Paul, Greeley, Colorado

SCIOTO COUNTY

Gatti, Frank G., Portsmouth
Wachter, Frederick E., Portsmouth

SUMMIT COUNTY

Brady, Richard M., Akron
Gould, Ned Trump, Akron
McGreevey, John F., Akron

What To Write for

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

What Should I Do? Pamphlet contains advice for prevention of accidents to children; what to do in case injuries do occur; convenient immunization record blanks and space for emergency telephone numbers. Available free from the Committee on School Health, Ohio State Medical Association, 79 E. State St., Columbus 15.

Safe Handling of Cadavers Containing Radioactive Isotopes. This 15-page handbook written by a subcommittee of National Committee on Radiation Protection, is available from the Government Printing Office, Washington 25, D. C., for 15 cents.

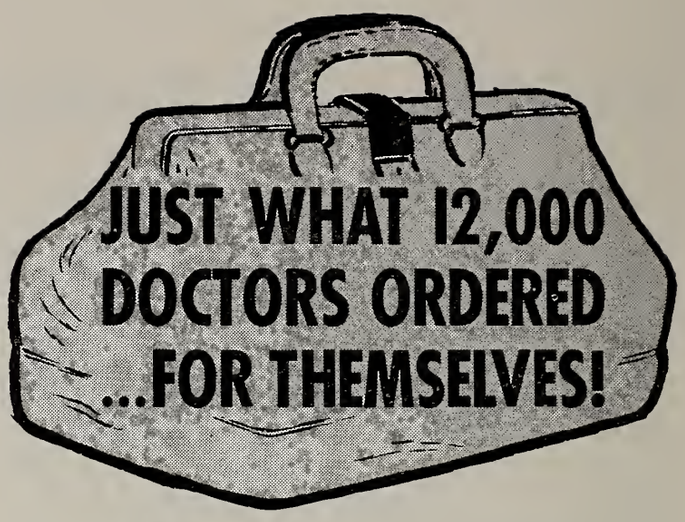
Trade Practice Rules for the Hearing Aid Industry. Promulgated August 7, 1953, it is a revision of rules issued by the Commission in 1944. Directed to the "elimination and prevention of various unfair trade practices and issued in the interest of protection of the buying public against deception . . .," it is available from D. C. Daniel, Secretary, Federal Trade Commission, Washington, D. C.

Approved Schools of Practical Nursing. Lists schools accredited by the National Association for Practical Nurse Education and/or a state accrediting authority. Write National Association for Practical Nurse Education, Inc., 654 Madison Avenue, New York 21, N. Y.

Suggested Standing Orders for School Medical Emergency Procedure (School Health Guide No. 3). This guide will help your school system work out standing orders to provide efficient action in case of illness or injury. Published by and available free from Committee on School Health, Ohio State Medical Association, 79 E. State St., Columbus 15.

Should Your Child Be a Doctor?, by Walter C. Alvarez, M. D., emeritus consultant in medicine, Mayo Clinic. From an article originally published as an advertisement . . . now a booklet, copies of which are available from its publisher, New York Life Insurance Company, 51 Madison Avenue, New York 10, New York.

Principles of Medical Ethics, the 1949 revision. Expresses in a general way the duty of the physician to his patient, to other members of the profession and to the profession at large, as well as of the profession to the public. Free from American Medical Association, 535 North Dearborn St., Chicago 10.





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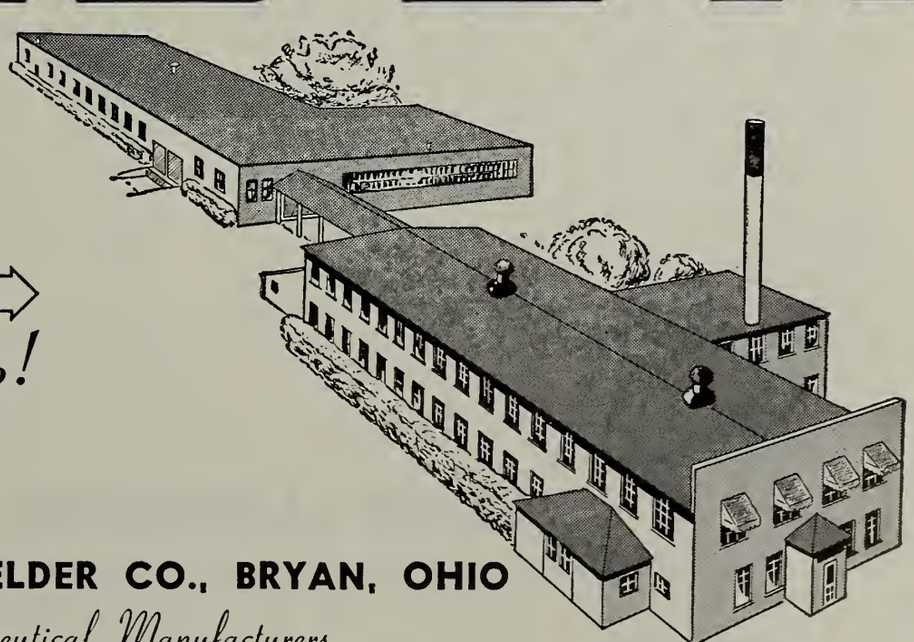
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Hospital Accreditation . . .

Joint Commission Announces Series of Standards of Interest to Physicians in Regard to Consultations, Attending Meetings, etc.

SEVERAL actions taken by the Board of Commissioners of the Joint Commission on Accreditation of Hospitals at its recent meeting will be of interest to physicians and hospital authorities in Ohio.

CONSULTATION STANDARD

The Board received a report on the "Consultation" Standard from a review committee. The Committee recommended and the Board approved the following as Standard REQUIRED II B 3:

"Except in emergency, consultation with a member of the Consulting or of the Active medical staff shall be required in all major cases in which the patient is not a good risk, or in which the diagnosis is obscure, and in all first caesarean sections, sterilizations, curettages or other operations which may interrupt a known, suspected, or possible pregnancy. The consultant shall make and sign a record of his findings and recommendations in every such case. In all cases where a rule of the hospital requires consultation, the consultant may, and in the case of free patients shall, give his services without charge. This Standard is applicable to all members of the medical staff."

The Board asked the Committee on Consultations to continue its study and report back after July 1, 1954. The Committee would appreciate comments or suggestions from any interested individual or group as to the Standard on Consultations as stated above and should be followed now by hospitals and their medical staffs.

GENERAL PRACTICE

The Board passed a resolution commending the American Academy of General Practice for its initiative in developing the Manual on General Practice Departments in Hospitals as a guide in the organization of such departments.

On December 6, representatives of the Joint Commission met with the members of the Commission on Hospitals of the American Academy of General Practice. The group discussed the underlying principles of medical staff meetings, as published in the August *Bulletin* of the Joint Commission.

Such staff meetings are held for the purpose of a thorough review of the medical care of patients, in or recently discharged from the hospital, and frequent meetings of clinical departmental staffs are regarded as essential in well-organized departmentalized hospitals.

ATTENDING MEETINGS

After the discussions, the following was stated as proper:

In a well departmentalized hospital electing to hold at least monthly clinical departmental meetings and quarterly general medical staff meetings in accord with CONTINGENT II, A 4 b, a doctor who holds an "active staff" appointment in a Department of General Practice should attend at least nine (75 per cent of 12) departmental meetings per year held by the clinical services in which he has privileges in addition to 75 per cent attendance at the quarterly meetings of the entire active medical staff. One of the two following patterns for attendance at clinical departmental meetings should be followed by "an active staff member" of a Department of General Practice:

(1) If he has privileges as an "active staff member" in a clinical department, he should attend 75 per cent of the monthly meetings of that department just as all other active staff members of that clinical department. It is understood that no physician will have "active staff" appointment in more than one clinical department.

OR

(2) If he has privileges other than as an "active staff member" in clinical departments, he should attend at least nine departmental meetings per year among the clinical services in which he has such privileges. The clinical departmental meetings attended shall be of his own choice, with the exception that he might be requested to attend a particular departmental clinical meeting.

This does not mean general practitioners must attend 75 per cent of the monthly meetings of every clinical service on which they have priv-

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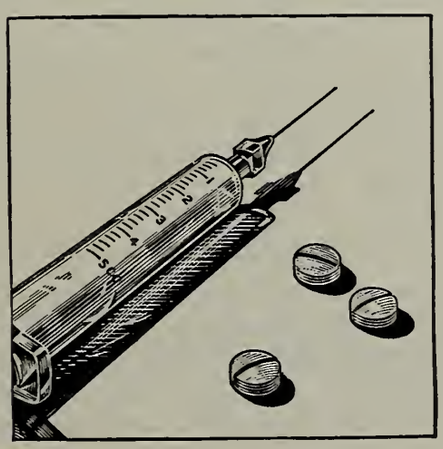
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ileges. They can fill attendance requirements by attending each month the staff meeting of any clinical service on which they hold an active or associate appointment, and are allowed three absences per year like other staff members.

The Director reported that during the first eleven months of 1953, the Board had acted on 1,175 hospital surveys. The Commission began actual survey operations January 1, 1953. A listing of Fully and Provisionally Accredited Hospitals as of December 31, 1953, will be published soon.

MAJOR DEFICIENCES

The Board was informed that the field staff had observed the following factors affecting patient care as the major deficiencies noted during their surveys:

1. Fire hazards.
2. Need for improvement in the active supervision of the clinical work done in the hospital by a well organized medical staff which is self-governing, subject to the ultimate authority of the governing body of the hospital.
3. Need for improvement in the thorough review, analysis, and evaluation of the clinical work done in the hospital on at least a monthly basis throughout the year.
4. Insufficiently recorded essential clinical entries on the medical records to establish the diagnosis and support the treatment.
5. Excessively high and unexplained rates for morbidity, Caesarean Sections, "not justified" removal of "normal tissue" and infant, maternal, anesthetic and total mortality in a hospital.

A. M. A. Exhibit in Nation's Capital

By special invitation of the museum, the American Medical Association will display its exhibit, "The Organs of the Human Body," at the Smithsonian Institution in Washington, D. C., during 1954. After this year, this exhibit will be available for showings in other museums throughout the country.

A new exhibit—"The Physician's Responsibility in Highway Accidents"—calls the doctor's attention to the fact that he should warn patients about the dangers of driving while under the influence of sedatives, antihistamines or anticonvulsive drugs. For professional showings only, this exhibit may be booked through the A. M. A.'s Bureau of Exhibits.

Toledo—Guest speaker at a joint meeting of the Toledo Kiwanis and Exchange Clubs was Dr. C. P. Rhoads, director of the Sloan-Kettering Institute for Cancer Research in New York City.

Troy—Dr. Paul E. Foy is the 1954 chief of staff of Stouder Memorial Hospital.

Hotel Space in San Francisco For 1954 A. M. A. Session

Physicians planning to attend the 1954 Annual Session of the American Medical Association, June 21-25, in San Francisco, should immediately write for hotel space, unless they have already taken care of this important matter.

Information on how to secure hotel space is published from time to time in *The Journal of the A. M. A.* This includes an application blank which should be sent to Dr. John J. O'Connor, American Medical Association Housing Bureau, Room 200, 61 Grove Street, San Francisco 2, Calif. A binder check amounting to $5.00 per person or a minimum of $10.00 per room should be sent with the application blank.

Watch your A. M. A. *Journal* periodically for detailed information on this.

Borden Company Localizes Ads To Salute Ohio Communities

The infant formula product manufacturer and the medical profession are both highly conscious of the importance of public relations at all operating levels. Latest evidence of this is the series of test advertisements appearing in *The Ohio State Medical Journal* in which The Borden Company's Prescription Products Division salutes the medical profession in selected Ohio cities. General response to these ads in this journal, one of four state journals selected for the test, has prompted the Company to extend the ad campaign.

Through this medium, Borden's hails the newborn babies of these selected cities and the physicians, hospitals and pharmacies which bring them the high standards of American medicine. This Borden division, which produces and ethically promotes infant formula products, features Bremil, Mull-Soy and Dryco in the city salute ads.

Institutional in character, the advertising copy points up the community aspect of the national organization. The Borden name has a 100-year history in the field of infant feeding, since it was in 1853 that the Company's founder, Gail Borden, originated preserved milk to provide safe nutrition for babies.

Advertisements which have appeared in the October, November and December, 1953, issues of *The Journal*; in the January, 1954, and in this issue, have featured the cities of Lorain, Hamilton, Columbus, Massillon and Canton. Springfield will be saluted in the March issue of *The Journal*.

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300—	"	40.00	"	26.50
400—	"	47.50	"	30.00
500—	"	52.00	"	35.00
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Food Service Regulations . . .

Ohio Department of Health Issues Uniform Sanitary Standards Under New Food Law To Govern Procedures of Local Health Organizations

A SET OF administrative regulations and uniform sanitary standards governing food service operations in Ohio has been issued by the Ohio Public Health Council and are now in effect. The regulations and standards were issued under the provisions of a law enacted by the State Legislature in 1953 and now known as Sections 3732.01 to 3732.08, inclusive, and Section 3732.99, of the Revised Code of Ohio.

Copies of the regulations may be secured from the Ohio Department of Health or from local health commissioners.

The responsibility for enforcement of the regulations and the licensing of food service establishments rests with local health departments.

"Food Service Operation is defined as:

"Two or more food serving areas supplied primarily by a common kitchen all of which are located in one building or structure and conducted under one operation shall be considered as a single food service operation. This definition shall not apply to operations serving only ice cream, frozen dessert novelties, milk served in the original container or through vending machines, soft drinks, nuts, candy, and similar confections."

"Meals or lunches" are defined as meaning soup or solid nutriment other than ice cream, candy, popcorn, nuts, and similar confections and "similar confections" means such products as frozen desserts, hot chocolate, ice cream sodas, ice cream sundaes, and milk shakes, in their various forms.

EXAMPLES

The following are examples of "food service operations" as defined in the regulations.

Soda fountains, lunch counters, and other similar places serving soups, cookies, crackers, doughnuts, sandwiches, or other solid food;

Independent operations serving or selling hot lunches, wrapped sandwiches, or other solid food to the consumer;

A catering operation preparing and packaging foods and serving such packaged foods direct to the consumers by either the operator or his employees;

A catering operation preparing food in bulk and serving such food in individual portions at some place other than the place of preparation, such as in a factory;

Places where any of the following food service equipment is provided; stoves, facilities for dishwashing, dishes and silverware; even though only occasional meals or lunches are served in such places.

FEES FOR CERTAIN CLASSES OF OPERATIONS

Dr. John D. Porterfield, director of the Ohio Department of Health, on January 7 issued the following memorandum pertaining to "Food Service License Fees for Certain Classes of Operation":

MEMORANDUM

Almost every local health district has adopted a fee schedule in accordance with Section 3732.03 of the new food service sanitation law and has had it approved by the Public Health Council.

Although a number of problems still call for solution in the initiation of this program, most of these will be met by equitable and realistic interpretation of the law and regulations and by full exchange of information.

One problem which has arisen in a number of areas and which has been the subject of discus-



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excellent toleration — Widely used among patients of all ages, this tested broad-spectrum antibiotic is well tolerated.[5,6]

1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. *53*:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. *74*:261 (June) 1950.
4. Wolman, B., et al.: Brit. M. J. *1*:419 (Feb. 23) 1952.
5. Potterfield, T. G., et al.: J. Philadelphia Gen. Hosp. *2*:6 (Jan.) 1951.
6. King, E. Q., et al.: J.A.M.A. *143*:1 (May 6) 1950.

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sion with state representatives of concerned organizations has been the fee to be charged "non-profit" food service operations. The law specifically provides a one dollar fee for **churches, hospitals, schools and institutions.**

OTHER NON-COMMERCIAL PLACES

There may, however, be other sponsors of non-profit, non-commercial food service operations such as certain agricultural or fraternal organizations which provide occasional meals for charitable fund-raising or for their own members without profit. This department cannot legally exempt such licensees from the three dollar fee to be remitted to the state.

If it seems proper and desirable to the local board of health, an addendum may be made to the approved fee schedule, setting a special fee for such licensees which would be adequate to cover the amount required to be submitted to the state plus a nominal income for the local board's program fund.

Such an action is entirely within the discretion of the local board of health, but if taken would not be objected to by this department's staff nor by the Public Health Council. Care should be taken, in such event, that such minimum fee be allowed only to those licensees which are bonafide non-commercial operations.

The need for sanitary protection of the public health is present in all mass-feeding operations, regardless of sponsorship. Every effort that can be made toward emphasizing that this program is an educational one in the interest of public health will help in its acceptance.

This department is making every effort to assist in making this a successful program. Information and questions are earnestly solicited.

Polio Research Project in Cincinnati Receives Continuation Grant

The polio research project under direction of Dr. Albert B. Sabin at the University of Cincinnati Children's Hospital, has received a continuation grant of $87,566.00 from the National Foundation for Infantile Paralysis.

Commenting on the grant, Dr. Sabin said that during the last few months he and his associates finally succeeded in converting each of the three types of polio virus from the virulent, paralyzing variety into nonvirulent, nonparalyzing but still immunizing varieties. This was accomplished by a special, selective process of cultivating in tissue cultures of monkey kidneys. Either injection or feeding of very small amounts of these modified viruses has produced immunity in monkeys.

The 1954 studies will attempt to determine whether or not and how this discovery may be applied to human immunization against poliomyelitis.

Two Indicted On Charges of Backing Medical Diploma Mill

The following article was published in the *Cleveland Plain Dealer* on January 14, 1954, under the by-line of Robert J. Drake, a *Plain Dealer* reporter:

Edward M. B. Ownen, wanted here on an indictment charging operation of a medical "diploma mill," has been arrested in his home in Arcadia, Mo., Sheriff Joseph M. Sweeney was notified yesterday.

Ownen refused to waive extradition. Sweeney said papers would be prepared immediately for forwarding to the governor of Missouri through Gov. Frank J. Lausche.

The 73-year-old head of the American Non-Allopathic University in Arcadia was released on $3,000 bail by a local magistrate and hearing was set for Jan. 22, the sheriff of Ironton County told Sweeney.

Ownen, with Robert J. Broadwell, former osteopathic hospital technician here, was indicted for larceny by trick and offering to sell medical diplomas from his school.

While Ownen resisted a return trip to Ohio, where he has been advertising his school among unlicensed practitioners, the Missouri state board of medical examiners reported evidence that the "university" was accepting aliens as candidates for degrees largely unrecognized in this country.

John A. Hailey, executive secretary of the Missouri board in Jefferson City, said Ownen wrote under date of last Aug. 1 to the American consul general in Athens, Greece, saying in part:

"This is to certify that one Ruissa R. Cadence, Athens, Greece, has been accepted for training for one year at this state chartered university and that the cost for tuition, board, room and textbooks will be $1,250 for this period.

"The university has been approved, as you know, by the United States Department of Justice, Immigration and Naturalization Service, as of May 13, 1952."

The school is recognized neither in Missouri nor in Ohio. Hailey said the board would attempt to get its charter revoked.

Until he ran into trouble here Ownen was listed as associate editor of the Ohio Chiropractic Bulletin, published in Columbus largely by and for unlicensed practitioners.

The current issue of the bulletin no longer lists Ownen, but an advertisement offers $500 reward for information leading to the return of stolen documents and the arrest and conviction of parties who took them from Ownen's office in Arcadia late in November. Papers and $1,700 in cash were reported stolen.

Cincinnati—Dr. C. Roy Steinbrube was named director of Sector 2, Zone 4, Hamilton County Defense Unit.

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State Medical Board Examinations . . .

83 Graduates of Medical Schools Seek Licenses To Practice in Ohio; List of Questions Are Given; Many in Limited Fields Also Examined

THE State Medical Board of Ohio on December 17-19 gave examinations to 83 graduates of medical schools who were candidates for licenses to practice medicine and surgery in the State, Dr. H. M. Platter, Secretary of the Board, reported.

In addition it gave examinations to 21 persons seeking licenses to practice osteopathic medicine and surgery. In the limited practice fields, it examined 4 chiropodists, 21 mechanotherapists, 51 chiropractors, 27 masseurs and 3 cosmetic therapists.

Results of the examinations were scheduled to be announced following a meeting of the Board on January 26, too late for this issue of *The Journal.*

Following are the questions given in the examinations for doctors of medicine:

ANATOMY

1. Describe the cervical portion of the sympathetic nervous system.
2. Give the branches of the abdominal aorta and their distribution.
3. Describe the construction of the orbit.
4. Give origin and insertion of muscles attached to linea aspera.
5. Describe the lymph drainage of the pelvic viscera.
6. What are the anatomical structures involved in amputation of leg at upper third of the thigh?
7. Describe the carotid sinuses. What do they drain and where empty?
8. Locate and give relations of the femoral canal.
9. Describe the wrist joint.
10. What are the various cavities draining into the nasal cavity and where does each drain?

PHYSIOLOGY

1. Discuss the role of the cerebral cortex in the control of motor responses.
2. Discuss the dietary requirements of the body for proteins.
3. Discuss the origin of the waves and the characteristics of the electroencephalogram. What are the normal variations?
4. Discuss the control of the external secretion of the pancreas.
5. Describe the origin and the composition of the lymph of the thoracic duct. What factors determine its rate of flow?
6. Discuss the factors that must be in balance if body weight is to be maintained at a constant level.
7. Discuss the physiology of the parathyroid glands.
8. Discuss the role of various endocrine glands in reproduction in the female primate.
9. (a) Give an explanation of the statement "excitability is a property of all living tissue."
   (b) What are the requirements that must be satisfied if a stimulus is to be effective?
   (c) By what mechanism does a stimulus evoke a response?
10. Discuss the physiology of the adrenal cortex.

BACTERIOLOGY

1. What is understood by the exo-erythrocytic cycle as applied to the infection of man by the plasmodia of malaria?
2. Name two diseases, one bacterial and one viral, in which serologic tests are most often the chief laboratory diagnostic aid.
3. What do you consider the most valuable diagnostic aid in brucellosis and give its interpretation.
4. Name four organisms commonly found in the "normal flora" of the body or in the soil that may cause disease in man.
5. Give two examples of spore bearing pathogenic organisms and discuss the influence of that bacterial property in disease production.

DIAGNOSIS

1. Give the clinical manifestations and diagnosis of Hodgkin's disease.
2. Give the differential diagnosis between: (a) Carcinoma of the head of the pancreas, (b) Laennec's cirrhosis of the liver.
3. State the symptoms and physical signs presented by a patient suffering from dissecting aneurysm of the descending aorta.
4. Give three causes of pyelophlebitis and multiple hepatic abscess.
5. Give the symptoms and the results of laboratory and X-ray studies that may be expected in hyperparathyroidism.
6. List in the order of frequency the causes of hematemesis.
7. Differentiate between hyperthyroidism and an anxiety state with cardiac manifestations.
8. List the principal differences between rheumatoid arthritis and degenerative joint disease (osteoarthritis).
9. Outline the diagnosis of gout.
10. List the causes of (a) purulent, (b) hemorrhagic, (c) fibrinous, and (d) serous pericardial effusions.

CHEMISTRY

1. Discuss the calcium of the blood as regards: (a) the concentration; (b) the form in which it exists; (c) response to hormones.
2. Describe briefly the oxidation of fatty acids in the body.
3. Discuss the part played by phosphorous compounds in the generation and the transfer of energy in the body.
4. Name 2 vitamins of importance in each of the following: (a) the integrity of bone; (b) the prevention of dermatitis.
5. Discuss briefly one of the following: (a) the iodine content of the blood; (b) the metabolism of nervous tissue.

MATERIA MEDICA AND THERAPEUTICS

1. Give the mechanism of anaphylaxis.
2. (a) By what mechanisms may cardiac arrest take place during anesthesia? (b) Give the treatment.
3. Give the pharmacological action of ergot and its uses.
4. Give the method of administration, dosage and duration of effect: (a) Mucoitin polysulfuric acid (heparin); (b) 3.3′ methylene bis (4 hydroxycoumarin (Dicoumarin).
5. What are the essentials of an ideal hypnotic?
6. Outline the treatment of gout.
7. Outline the effect of 1st - 2nd - 3rd - 4th plane of anesthesia upon respiration, eyelid reflex, eyeball activity and pupils.
8. Give the prophylactic treatment to be followed by a patient that has recovered from an attack of rheumatic fever.
9. Outline treatment of acute glomerular nephritis.
10. (a) Name two drugs which stimulate the medulla.
    (b) Give dosage.

PRACTICE

1. Give the clinical manifestations of a patient suffering from extracellular fluid deficit—intracellular fluid normal.
2. Give five common causes of recurrent attacks of syncope.
3. (a) Define osteoporosis. (b) Enumerate clinical types.
4. Describe the clinical picture of adrenal cortical hyperfunction.
5. Give the signs and symptoms of infectious mononucleosis.
6. Discuss briefly the treatment of pernicious anemia, indicating the newer drugs used and their limitations.
7. In what circumstances should a patient with duodenal ulcer be treated (a) by medical means, and (b) by surgical means?
8. Distinguish between tertian and estivo-autumnal malaria as to treatment.
9. Name two anticoagulant drugs. Discuss the indica-

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tions for their use, the methods of administration, and the precautions required for safety.
10. Outline the immediate treatment of a patient with an uncomplicated acute myocardial infarction who is seen six hours after the onset.

PATHOLOGY

1. Name two diseases that may be complicated by occurrence of Zenker's hyaline necrosis (degeneration) of skeletal muscle.
2. Name the three most common sites of formation of solitary abscesses of the brain and in one sentence state the usual mechanism of infection involved in each.
3. In one sentence give the usual pathogenesis of massive hemorrage: (a) within the substance of the brain; (b) in the subarachnoid space; (c) in the lung; (d) in the pericardial cavity; (e) in the peritoneal cavity.
4. What disorder is likely to be accompanied by peripheral zonal necrosis of the liver? (b) What diseases may be accompanied by focal necrosis of the liver?
5. List the microscopical findings in the kidney in a fatal case of traumatic shock.
6. Name the principal features of that malformation of the heart called Tetralogy of Fallot.
7. List the gross features of chronic peptic ulcer of the duodenum.
8. Outline the gross and microscopical lesions of the central nervous system in a case of multiple sclerosis.
9. List the pathological anatomical lesions that characterize acromegaly.
10. In outline form contrast bacillary dysentery and amebic dysentery in respect to (a) etiology, (b) methods of establishing a laboratory diagnosis, (c) preventive measures.

SURGERY

1. Illustrate by diagram the position of bones in Colles' fracture.
2. A boy, fourteen years of age, is brought in the hospital in moderate collapse after a coasting accident. He complains of pain on breathing and tenderness over the left tenth rib in the axillary line. Discuss the differential diagnosis and the treatment.
3. What are the symptoms and physical signs of regional ileitis? What other evidence is necessary for the diagnosis?
4. Discuss briefly the important factors in the pre- and post-operative care of a patient who has acute intestinal obstruction.
5. Give the differential diagnosis in a case of acute pain in the lower right abdominal quadrant of an adult male.
6. Discuss the diagnosis and management of amebic abscess of the liver.
7. State the usual causes of nonunion of fractures.
8. Give the causes, symptoms, and treatment of Volkmann's contracture (ischemic paralysis).
9. Discuss the causes, symptoms, and treatment of carbuncle.
10. Discuss the pathological physiology and management of traumatic shock.

OBSTETRICS AND GYNECOLOGY

1. Discuss the conditions which must be fulfilled before forceps can be applied.
2. Outline proper pre-natal care with attention to all phases that are important.
3. Give symptoms, causes and treatment of tubal pregnancy.
4. Outline diagnosis and treatment of acute salpingitis.
5. Give causes and treatment of sterility.
6. Describe the anatomical supports of the uterus.
7. Discuss the care of the premature infant.
8. Discuss management of Placenta Praevia: (Centralis; (b) Marginalis.
9. & 10. **True or False:**
   (a) Occiput posterior presentations usually result in prolonged labor.
   (b) Pfeiffer forceps are designed for use on the after-coming head in breech deliveries.
   (c) A tense painful uterus in the last trimester of pregnancy associated with evidence of shock is usually due to abruptio placentae.
   (d) A platy pelloid pelvis has an anterior posterior diameter smaller than that of the normal.
   (e) In an incubator for premature babies, a surplus or high saturation of oxygen is desirable.
   (f) Primary dysmenorrhoea may be caused by a neurosis, notably hysteria.
   (g) Mittelschmerz is a term used to designate periodic intermenstrual pain.
   (h) Colpitis is an inflammation of the vaginal tube.
   (i) The true conjugate is not important in pelvimitry.
   (j) The gynecoid pelvis is the one most often found in South America.

SPECIALTIES

1. What is lupus erythematosis? Diagnosis?
2. Pain in the region of the auricle would make one suspicious of what condition? Give differential diagnosis.
3. (a) Draw a diagram of the lateral wall of the left

Cook County Graduate School of Medicine

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GYNECOLOGY—Gynecology Course, two weeks, starting Mar. 15. Vaginal Approach to Pelvic Surgery, one week, starting Mar. 1.

OBSTETRICS—Obstetrics Course, two weeks, starting Mar. 1. Combined Course in Gynecology & Obstetrics, three weeks, starting April 19.

MEDICINE—Two-Week Intensive Course starting May 3. Electrocardiography & Heart Disease, two weeks, starting Mar. 15.

PEDIATRICS—Congenital & Rheumatic Heart Disease in Infants & Children, one week, starting April 19 and April 26.

UROLOGY—Intensive Course, two weeks, starting April 19. Ten-Day practical course in Cystoscopy every two weeks.

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nasal passageway, labeling the important parts. (b) Remove the turbinates and show underlying structures.
4. A man comes in to your office with a complaint of urethral discharge. Discuss diagnosis and treatment.
5. Differentiate conjunctival and ciliary injection.

PREVENTIVE MEDICINE AND HYGIENE

1. Name four metals that may produce "metalic poisoning." Tell the usual way the poisoning is caused and give general methods of prevention of such poisoning.
2. Discuss fluoridation of public water supply with regard to the advantages and disadvantages to teeth of children.
3. What measures should be employed to prevent bacillary dysentery?
4. What are the general principles of the prevention of allergic reactions?
5. In inspection of public eating places and restaurants, what are the points to be observed and stressed to avoid disease outbreaks?

Licensed Through Endorsement by State Medical Board

The State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians through endorsement of their licenses to practice in other states (intended residence and medical college of graduation also are given):

October 6—James V. Kennedy, Utica, Columbia University; Richard R. Patterson, Cleveland, Queen's University, Canada.

December 18—Robert A. Barnett, Akron, George Washington Univ., Harold E. Bowman, Cleveland, Indiana Univ.; Michael L. Cancilla, Columbus, Univ. of Michigan; Vasile G. Coseriu, Youngstown, Univ. of Cluj, Roumania; Henry M. Cryer, Jr., Cleveland, Hahnemann Medical College; William R. Culbertson, Jr., Cincinnati, Vanderbilt Univ.;

Harvey F. Doe, Edgerton, Jefferson Medical College; Donald H. Endean, Columbus, Wayne Univ.; Clarence E. Everhart, Jr., Cleveland, George Washington Univ.; Norman Fisher, Cleveland, Boston Univ.; Richard E. Flood, Jefferson Medical College;

Arnold S. Gale, Cleveland, Harvard Medical School; Joseph M. Garland, Toledo, Yale Univ.; H. Wayne Glotfelty, Piqua, Univ. of Louisville; Birt Harvey, Wilmington, New York Univ.; Frank H. Healey, Jr., Solon, Tufts Medical School; Benjamin Kaplan, Cincinnati, Univ. of Illinois; Lowell L. Keirle, Cincinnati, Cornell Medical College; George Kelemen, Univ. of Budapest, Hungary;

Jerome Z. Litt, Cleveland, Chicago Medical College; Henry E. McWhorter, Toledo, Univ. of Chicago; Isaac E. Michael, Marion, Rush Medical College; Samuel T. Nicholson, Jr., Toledo, Johns Hopkins; Edward I. Panzer, Univ. of Palermo, Italy;

John Y. Ranchoff, Cleveland, Univ. of Buffalo; Clark G. Reed, Cleveland, Duke University; Matyas Relle, Univ. of Ludwig Maximilian, Munich, Bavaria; Paul A. Saxon, Worthington, College of Medical Evangelists; Louis H. Scharf, Youngstown, Univ. of Prague, Czech.; William C. Schmelzer, Columbus, Georgetown Univ.; Murry D. Schonfeld, Cincinnati, Harvard Medical School; James A. Schuler, Marion, Loyola Univ.;

Gerard Seltzer, Cleveland, New York Univ.; Richard T. Silvers, Canton, Univ. of Pennsylvania; Cesar Somoza, Akron, Univ. of Madrid, Spain; Jonas Stankaitis, Univ. of Kaunas, Lithuania; Joseph A. Szolomajer, Euclid, Univ. of Graz, Austria;

Francis J. Tenczar, Cincinnati, Univ. of Illinois; Frederick W. Tillotson, Cleveland, Univ. of Colorado; Sidney Walk, Univ. of Lausanne, Switzerland; Isom C. Walker, Jr., Cincinnati, Duke Univ.; Louis M. Walker, Akron, Northwestern Univ.; Joe M. Webber, Dayton, Albany Medical College; Theodore R. Whitaker, Univ. of Pittsburgh; Richard E. Wineland, Mansfield, Univ. of Michigan.

Urbana—Medical staff officers of the Mercy Memorial Hospital for 1954 are Dr. Isadore Miller, president; Dr. Lewis Inskeep, vice-president, and Dr. F. R. Grogan, secretary-treasurer.

Warren—Dr. J. M. Gledhill was named president of the Trumbull Memorial Hospital medical staff, with Dr. R. K. Whiteman, vice-president, and Dr. Abraham Hoodin, secretary-treasurer.

Akron—Dr. Edward L. Voke spoke on the subject "X-Ray and Radium in Medicine" at a meeting of the Optimist Club.



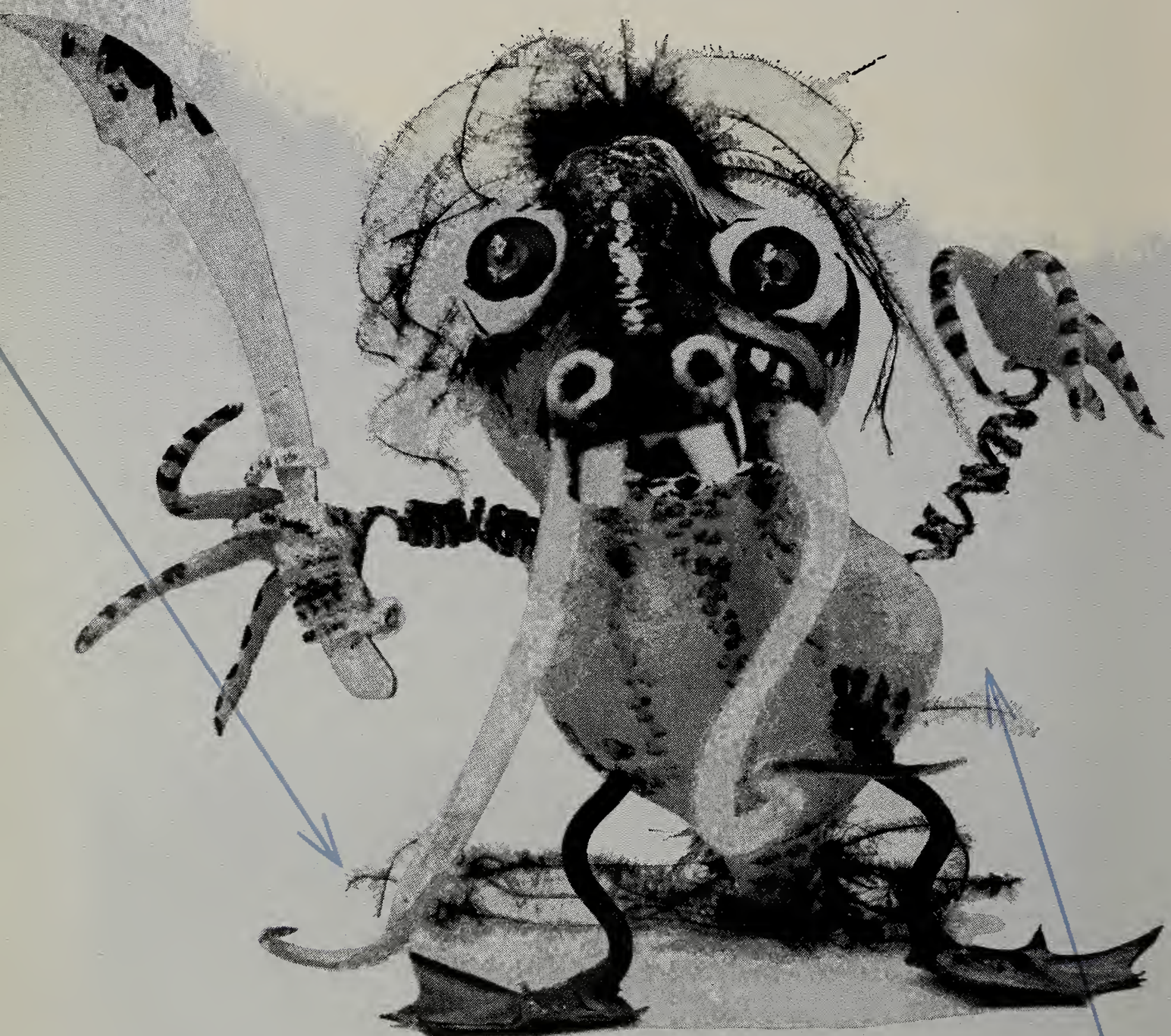
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1. Grigsby, M. E., et al., Antibiot. & Chemother., 10:1029, October, 1953.

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In Memoriam . . .

George E. Clarke, M. D., Cincinnati; University of Illinois College of Medicine, 1920; aged 59; died December 11; former member of the Ohio State Medical Association, last in 1949. Dr. Clarke had been a practicing physician in Cincinnati for about 20 years before his retirement nearly two years ago. He was an instructor in dermatology and syphilology at the University of Cincinnati College of Medicine. A veteran of both World Wars, he was a member of the American Legion and was active in the National Guard. Affiliations included the Masonic Lodge, the Cuvier Press Club and the Episcopal Church. Surviving are his widow and two sisters.

Holway D. Farrar, M. D., San Diego, Calif.; Starling Medical College, Columbus, 1898; aged 80; died December 8. Formerly a practicing physician in Columbus, Dr. Farrar moved to California about 25 years ago. Survivors include his widow, a son and a daughter.

Robert C. Hebble, M. D., Springfield; Starling Medical College, Columbus, 1895; aged 79; died December 5; member of the Ohio State Medical Association; past-president of the Clark County Medical Society. Mr. Hebble had practiced a total of 57 years and had received the 50-Year Pin and Certificate of the Ohio State Medical Association. He began practice at Enon, his native town, and in 1916 moved to Springfield. A 32nd Degree Mason, he was active in several of the Masonic Bodies and was a member of the Methodist Church. Survivors include his widow and a son, Dr. Joseph N. Hebble, Springfield health director.

Charles M. Hendricks, M. D., El Paso, Texas; Medical College of Ohio, Cincinnati, 1905; aged 75; died December 9. Formerly of Eaton, Dr. Hendricks had been in Texas for many years. He is survived by his widow, four daughters and three sisters.

Walter Eugene Horn, M. D., Portsmouth; Ohio State University College of Medicine, 1943; aged 35; died December 15; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Horn had been practicing in Portsmouth only a short time after serving approximately 10 years in the Army Medical Corps. Survivors include his parents, a brother and a sister.

Frank Cottrell Jackson, M. D., Dayton; Ohio State University College of Medicine, 1927; aged 51; died December 19; member of the Ohio State Medical Association. Upon completion of his medical education, Dr. Jackson entered practice in Columbus and for many years was city physician. During World War II, he entered the Army Medical Corps and served overseas. After the war, he served with the Veterans Administration. His widow survives.

Howard Stanley James, M. D., Hartwell (Cincinnati P. O.); Miami Medical College, Cincinnati, 1907; aged 73; died December 20; member of the Ohio State Medical Association; member of the American Medical Association. Dr. James, before his retirement about five years ago, had practiced for many years in the Wyoming area. He was a member of the Presbyterian Church and the Masonic Lodge. Survivors include his widow and two daughters.

Wilbur Anthony Ricketts, M. D., Dayton; Ohio State University College of Medicine, 1923; aged 57; died December 28; member of the Ohio State Medical Association; member of the American Medical Association; member of the American College of Surgeons; president of the Montgomery County Medical Society, 1940. Dr. Ricketts practiced for more than 28 years in Dayton. Active in professional and civic affairs, he was a past-president of the Dayton Obstetrical Society and was a founder of the Dayton Maternal Health Association. Other affiliations included the Baptist Church, the Dayton City Club, Delta Upsilon, Alpha Kappa Kappa, Phi Sigma and the Masonic Lodge. Surviving are his widow, a daughter, a son and a sister.

James Milton Scott, M. D., Scio; University of Pittsburgh School of Medicine, 1910; aged 72; died December 3; member of the Ohio State Medical Association; member of the American Medical Association; president of the Harrison County Medical Society, 1930-1931 and active on several local committees. Dr. Scott had practiced his profession in Scio and vicinity beginning in 1913 and in 1952 was honored by a public celebration in his name. In later years he confined practice to his work with the Scio-Ohio Pottery dispensary. He was a 32nd Degree Mason, a member of the Presbyterian Church, the Knights of Pythias Lodge and the Grange. Survivors include his widow, two sons, one of whom is Dr. James Scott of Pittsburgh, and a sister.

Paul Jacob Stueber, M. D., Lima; University of Michigan Medical School, 1912; aged 67; died December 22; member of the Ohio State Medical Association; member of the American Academy of Ophthalmology and Oto-Laryngology; diplomate of the American Board of Ophthalmology; vice-president and president of the Academy of Medicine of Lima and Allen County in 1940 and 1941, respectively. Affiliations included memberships in the T and T Club and the Evangelical and Reformed Church. Survivors include his widow; a son, Dr. Paul J. Stueber, Jr., of Cleveland; and a sister.

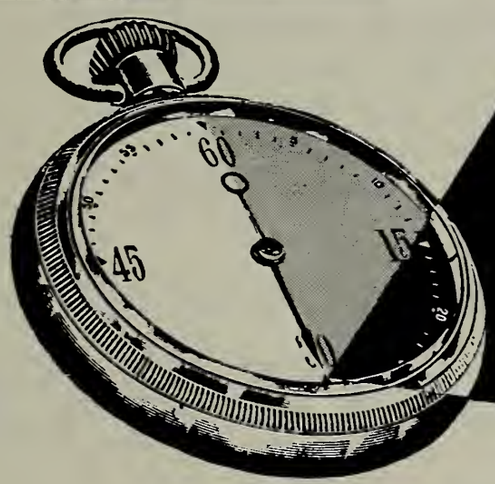
Henry Hamilton Wiggers, M. D., Cincinnati;

Pulte Medical College, Cincinnati, 1892; aged 84; died December 23; member of the Ohio State Medical Association and the American Medical Association; member of the American College of Surgeons. Dr. Wiggers practiced continuously in Cincinnati for 60 years with the exception of time occupied with postgraduate studies in Europe. He was a recipient of the 50-Year Pin of the Ohio State Medical Association. In addition to professional organizations, he held memberships in the Queen City Club, the Cincinnati Country Club, the Pelee Island Club and Alpha Sigma. Survivors include his widow, two daughters and a son.

Otis Wiles, M. D., Lexington (Richland County); Western Reserve University School of Medicine, 1892; aged 87; died December 24. Dr. Wiles served his entire professional career in the Mansfield and Lexington areas. He was active in civic enterprises of Lexington and was a member of the Presbyterian Church. Surviving are his widow, a daughter and a son.

Dale Wilson, M. D., Toledo; Toledo Medical College, 1901; aged 75; died December 14; member of the Ohio State Medical Association and the American Medical Association; member of the Clinical Orthopaedic Society and the American Academy of Orthopaedic Surgeons; Fellow of the American College of Surgeons; active in numerous committees of the Academy of Medicine of Toledo. A native of Toledo, Dr. Wilson served all of his professional career there, except for military service. He had been honored with the 50-Year Pin and Certificate of the Ohio State Medical Association. He was a veteran of the Spanish-American War and served with the Medical Corps during World War I and prior to that war on the Mexican border. During World War II, he worked with the procurement service. Organizations to which he belonged included the Elks Club and the American Legion. Surviving are his widow, a son, a daughter and a sister.

Rollin Duane Worden, M. D., Ravenna; University of Vermont College of Medicine, 1915; aged 64; died December 10; member of the Ohio State Medical Association; former vice-president and former delegate of the Portage County Medical Society. Dr. Worden moved to Ravenna in 1919, after serving in the Army Medical Corps during World War I. He served for a number of years as city health commissioner. Active in virtually all phases of community life, he was a member of the Rotary Club, the Kiwanis Club, the Elks Lodge, the Masonic Lodge, the Methodist Church, and the American Legion. Survivors include his widow, a daughter and a son.



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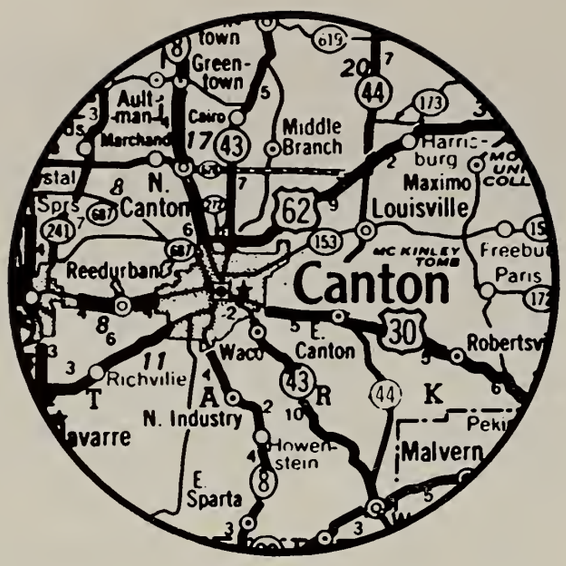
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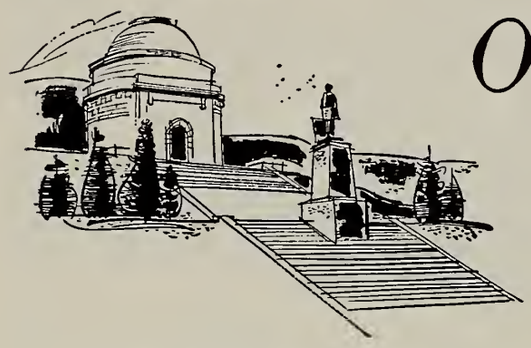
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Chest X-Ray Procedures . . .

Fundamentals on Desirable Steps and Methods Outlined in Official Report of Joint Committee of Chest Physicians and Radiologists

MANY Ohio physicians will be interested in the recently-issued report of the Joint Committee on Chest X-Ray of the American College of Chest Physicians and the American College of Radiology.

The report, which has the approval of the official boards of both organizations, contains many fundamentals as to desirable procedures in doing mass chest x-ray surveys. It serves as a guide to physicians and agencies interested in this field.

Text of the report, as published originally in *Diseases of the Chest*, official journal of the American College of Chest Physicians, reads as follows:

PURPOSE OF JOINT COMMITTEE

In establishing a Joint Committee on Diseases of the Chest, the purpose of the American College of Chest Physicians and the American College of Radiology is to exchange ideas and to propose guiding principles on the problems involved in routine chest x-rays in hospitals (general, mental, etc.), and mass chest x-ray programs. The committee agrees: that each physician should be encouraged to have a chest x-ray of all of his patients; that every patient admitted to a hospital private or public, should have a routine chest x-ray; and that the follow-up for all suspected lesions seen in chest x-ray surveys should be organized very carefully to assure that the patient comes under medical supervision.

LIMITS OF SURVEY

Routine chest x-ray examinations should be defined as those examinations of the chest which are conducted to screen persons with abnormal changes of the chest from persons with normal chests. The examinations are screening diagnostic procedures and are not to be considered as clinical diagnostic examinations. The screening method is for the purpose of detecting the presence or absence of a lesion only.

The size of the film which one uses for screening purposes is not of primary importance. The committee believes in principle, however, that when microfilms have been used, a 14x17 inch film is a necessary second step in the screening procedure and the mechanism whereby such is provided in any community shall be determined by the local medical society or the local hospital staff. Survey chest x-rays either in hospitals or in the general population are approved as a screening device if conducted by agencies which utilize well qualified professional and technical personnel and which make sincere efforts to send the positive individuals to qualified local physicians or clinics for proper follow-up.

INTERPRETATION AND REPORT

Interpretation and reporting of medical findings is a medical matter and should bear the signature or identification of the responsible physician.

METHOD OF REPORTING

Method of reporting of chest survey studies: This is a local matter and is by prearranged agreement between the employer and the employee in industrial surveys; in other surveys it is in accord with medical ethics, according to local agreement.

TYPE OF REPORTING

Type of reporting: The Committee discourages the reporting of suspicious cases as tuberculosis. It believes this to be a clinical diagnosis. The x-ray interpreter should designate the cases that require immediate follow-up as "urgent." The

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small film x-ray interpretation is merely an impression.

It should be emphasized that the 14x17 inch film is a diagnostic aid and the results derived therefrom are also impressions and not diagnoses. Even the larger film is but one of several examinations necessary in order to establish correct diagnoses.

DOUBLE READING

The committee notes the several publications indicating the extent of false negative and false positive reports resulting from inter- and intra-individual variations in interpretations of chest films. From these it is evident that failures to detect tuberculosis can be reduced by multiple readings, but at the expense of increasing the false positives, unless a check mechanism is employed. The simplest elaboration of multiple reading is the independent interpretation of the film by two physicians with referee conference of the two undertaken in those cases in which they disagree. Only those cases on which both agree in conference should be followed.

While such a procedure may result in the detection of a slightly larger portion of all the abnormal cases, it may not be feasible from an economic or personnel standpoint. Groups responsible for survey operations are urged by the committee to give consideration to double reading as one of the methods by which survey yields may be increased. Availability of financial resources and qualified professional personnel, as well as the need for other services of relative importance, will be determinates in this decision. The committee, therefore, calls attention to some of the virtues of double reading but does not recommend it unreservedly.

PROFESSIONAL COMPENSATION

The professional cost of performing routine chest examinations in hospitals: The Joint Committee believes the radiologist and/or chest physician should be compensated just as any other physician practicing his profession. The procedure is time consuming and places a definite responsibility on the radiologist or chest physician. The Committee likewise felt that in this matter the basic principle of payment is by arrangement between the physician and the hospital or agency involved. In the reading of follow-up films there should also be an individual limit to the number of films which should be read in any one day by one physician and which he should not exceed. The compensation, of course, would have to take into consideration, whether the physician makes the film in addition to interpreting it.

CLOTHING OF PATIENTS

Whether or not a screening examination can be conducted with the patient fully clothed: Since the number of lesions overlooked because of clothing (2 per cent) is considerably smaller than the normal variations of interpretation (Chamberlin, etc.) have demonstrated to exist in the reading of photofluorographic films, it is concluded that the examination of clothed persons is as effective a procedure as examination of the undressed persons. Since examination of the fully clothed persons is an easier procedure as compared with the examination of the undressed persons, the Committee agreed that screening examination may be conducted with the patient fully clothed.

READER'S QUALIFICATIONS

Qualifications of readers in mass chest surveys: It was believed at the present time there was no practical method which could be used to evaluate the qualifications of a particular reader. Studies in this respect are being made at the present time. It is hoped that within a short period of time satisfactory testing methods will be available. The committee therefore agreed to leave this matter open for further discussion.

PROTECTION

The radiation received by all professional, technical and clerical personnel associated with photofluorographic equipment should be continuously monitored by means of film badges or other devices which have been proved to be satisfactory for determining the radiation exposure of personnel.

When an individual receives more than 100 milliroentgens per week, the medical officer in charge of the unit should immediately determine whether the individual has been careless or whether the protective devices of the equipment are at fault.

If the fault lies with the individual, the individual should be informed of the fact and strongly cautioned regarding the dangers of excessive radiation exposure. Failure to regard such warning should be considered as negligence on the part of the individual.

If the fault lies with the equipment or protective devices, the photofluorographic unit should immediately be taken out of commission until

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such time that measurements of radiation conditions where technical or clerical personnel are required to work will yield radiation exposures less than 100 milliroentgens per week for case loads of 2,500 exposures at 95 kv. and 40 ma. seconds (the average exposure per photofluorographic chest film).

CONTINUATION OF STUDY

It is recommended that the Joint Committee arrangement continue and that the Joint Committee meet annually, or at the call of the co-chairmen. In an effort to have the Joint Committee act continuously and without interruption, interim ideas should be sent to the co-chairmen, and an exchange of opinion should continue during the intervals between meetings. Recommendations are solicited from all interested in the affairs of the Joint Committee.

Activities of County Societies . . .

CUYAHOGA

Five doctors who have served a half-century in the medical profession were honored by the Academy of Medicine of Cleveland. They are Dr. Wilfred E. Allyn, Dr. Wallace J. Benner, Dr. Morrison H. Castle, Dr. Hudson D. Fowler and Dr. Howard Landon Taylor.

Presentations of 50-Year Pins and Certificates were made by Dr. Charles L. Hudson, Councilor of the Fifth District of the Association, at the mid-December meeting.

A program on the subject of virus diseases was presented by the following speakers: Drs. F. C. Robbins, J. H. Dingle, R. G. Hodges, W. J. Jordan and H. S. Ginsberg.

DARKE

Regular monthly meeting of the Darke County Medical Society was held on January 19 at the Wiebusch Manor, Greenville. Speakers for the occasion were Dr. Paul Shank and Dr. Lovingood, of Dayton, who discussed, respectively, "Supraradical Mastectomy," and "Aortography."

FRANKLIN

Attendance at the series of "Columbus Health Forums" increased with each forum to reach a climax at the last meeting of more than 1,400 people who filled the Central High Auditorium to overflowing.

The series was sponsored in cooperation with the *Columbus Dispatch* which extended the lectures through good reporting to its readers.

MONTGOMERY

The Montgomery County Medical Society was one of the backers of the "Voice of Democracy" contest, sponsored by the Dayton Junior Chamber of Commerce among high school students. The Society donated a miniature trophy to be-



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TUSCARAWAS

At the business meeting of the Tuscarawas County Medical Society that followed the dinner on December 9, Dr. Van Epps, vice-president and president-elect, presided in the absence of President Banjamin Pilloff.

The following officers were elected: Dr. E. I. Miller, vice-president and president-elect; Dr. R. E. Rinderknecht, secretary-treasurer; Censor, Dr. Pilloff; Delegate and alternate, respectively, are Dr. H. E. Reed and Dr. P. W. Ebert. Dr. Van Epps is the incoming-president.

The January 14 meeting was held in the auditorium of Union Hospital, where Dr. Frederick Wentworth, chief of the Division of Communicable Diseases of the Ohio Department of Health, discussed the common communicable diseases with the latest ideas on prophylaxis and treatment.

Activities of Woman's Auxiliary . . .

By MRS. EDWARD L. VOKE, Chairman, Publicity Committee, 243 Hampshire Road, Akron 13, Ohio

President—Mrs. N. M. Reiff, 404 Rawlings Street, Washington Court House

President-Elect—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13

Vice-President—Mrs. O. W. Jepson, Bowen Road, Canal Winchester

Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge

Corresponding Secretary—Mrs. James E. Rose, 729 Washington Avenue, Washington Court House

Treasurer—Mrs. Karl Ritter, 1420 Shawnee Road, Lima

Past-President—Mrs. Paul M. Woodward, 1500 Hollywood Avenue, Cincinnati 24

BUTLER

The December luncheon meeting of the Butler County Auxiliary was held at the Golden Lamb. Mrs. Edward Kezur was chairman of arrangements. Mrs. W. F. Hume reported net proceeds of $3,619.00 from the horse show, and it was voted to use this money to purchase beauty parlor and barber equipment for the Butler County TB Hospital.

Miss Jeannette Niederlander gave a reading of *The Nativity* by Fulton Oursler.

CHAMPAIGN

Champaign County Medical Society and its Auxiliary held their annual Christmas dinner party at Cresent Farm on December 13. Dr. George A. Woodhouse, Second District Councilor, and Mrs. Woodhouse, of Pleasant Hill, were guests of the group.

DARKE

Darke County Auxiliary met November 17 for dinner in the Treaty Room of the James Hotel, followed by a business meeting at the home of Mrs. Westbrook Browne. The president, Mrs. Gil-





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bert Sayle, and Mrs. J. E. Gillette reported on the Fall Conference and discussed the American Medical Education Foundation. Mrs. John Alley was named chairman of the nurse recruitment committee. Mrs. Robert Prophater and Mrs. Browne were appointed chairmen of the annual Christmas party.

The following officers were elected: Mrs. Sayle, reelected president; Mrs. Prophater, secretary; and Mrs. E. W. Arnold, treasurer. Mrs. C. J. Mills was appointed public relations chairman.

The Auxiliary entertained the Medical Society and the hospital staff at a Smorgasbord at the James Hotel on Dec. 17. Eighty members and guests enjoyed games and a social hour.

DELAWARE

Miss Jeanne James of Columbus, executive secretary of the Central Ohio Heart Association, discussed new trends in conducting the heart drive at the December 8 meeting of the Delaware County Auxiliary held at the home of Mrs. E. V. Arnold.

Mrs. H. W. Davis presented a program on "Legislation." Members exchanged Christmas gifts and brought gifts to be taken to the County Home.

ERIE

The traditional holiday teas in honor of the personnel of Good Samaritan and Providence Hospitals were held simultaneously on December 17. Mrs. W. C. Seiler, chairman of the social committee of Erie County Auxiliary, supervised the arrangements. Hostesses at Providence included Mrs. H. G. Lehrer, Mrs. R. E. Taylor, Mrs. R. M. Knoble, Mrs. H. W. Lehrer and Mrs. G. A. Stimson. Mrs. C. J. Reichenbach, Mrs. D. M. Spencer, Mrs. C. R. Swanbeck, and Mrs. R. S. Merrill were hostesses at Good Samaritan.

Officers and past-presidents circulated at each party and took turns presiding at the tea tables.

FAIRFIELD

Members of the Fairfield County Medical Society were guests of the Auxiliary at a dinner party at the Lancaster Country Club on December 10. Mrs. J. J. Hoodlett was chairman of arrangements. During the evening, motion pictures taken by Dr. and Mrs. Leo Stenger on a trip to Hawaii and the Orient were shown.

HAMILTON

The annual dinner-dance of the Hamilton County Auxiliary was held on December 5 at the Maketewah Country Club. The dance is given each year for the benefit of the educational and philanthropic fund, of which Mrs. Byron E. Boyer is the current chairman. Mrs. Earl C. Van Horn was chairman of the dinner-dance, assisted by Mrs. William F. Hunting as vice-chairman, and a large committee.

(Editor's Note—Due to limited space, additional Auxiliary notes submitted for this issue will be printed in a subsequent issue.)

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Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, please address your letter as follows: Box___, c/o The Ohio State Medical Journal, 79 E. State St., Columbus 15, Ohio.

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FOR SALE: General practitioner retiring to Florida will sell fluoroscope, ultraviolet lamp, nose and throat compressor cabinet, file case, mahogany desk, swivel chair, and safe. E. C. Beam, M. D., 2588 Dorset Rd., Columbus 21, Ohio; Phone KI-8045.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Operative Surgery, by Guy W. Horsley, M. D., and Isaac A. Bigger, M. D. Two Volumes. ($30.00. Sixth Edition. *C. V. Mosby Company, St. Louis 3, Mo.).* A completely rewritten and revised edition of this well-known work of the surgical teachers of Richmond, Virginia. As in all previous editions, the emphasis is on function and the biologic processes that follow up on a surgical operation.

Problems of Infancy and Childhood, edited by Milton J. E. Senn, M. D., ($2.50. *Josiah Macy Jr. Foundation, 16 West 46th Street, New York 36, N. Y.),* is the Transactions of the Sixth Conference on the subject designed to promote understanding between men in different departments by effecting communication through the walls of the separate disciplines.

Love, Emotions and Your Health, by Norman Ober, ($0.35. *Modern Living Council, 17 East 45th Street, New York, N. Y.),* is a simplified guide to "psychosomatic medicine." It demonstrates by the use of case histories the corrosive effect of emotional attitudes. Teachings as old as the Judeo-Christian concept. Having lost contact with God, we now worship a mass of assumption we call Science.

Year Book of Pediatrics: 1953-54 Series. Edited by Sydney S. Gellis, M. D., ($6.00. *Year Book Publishers, Inc., Chicago 11, Ill.).* The advances as revealed by this standard work of reference during the past year have been considerable. To list some: continued improvement in the management and treatment of cardio-vascular diseases; the discovery of patients deficient in gamma globulin; the testing of gamma globulin in the prophylaxis of poliomyelitis; the experiments with the polio vaccine; the application of chromatography to metabolic disturbances of childhood; and great progress in the field of pediatric endocrinology.

The Psychopathic Delinquent and Criminal, by George N. Thompson, M. D., ($4.50. *Charles C. Thomas Co., Springfield, Ill.).* This book by its very title will appeal to a large number of readers with widely varying interest. Here each will find the information that he seeks done with complete detachment and objectivity based upon statistically reliable experience.

Immunity, Hypersensitivity, Serology, by Sidney Raffel, M. D., ($8.00. *Appleton-Century-Crofts, Inc., New York, N. Y.).* The author points out that antibodies appear regularly during the course of disease simply as a physiologic response of the body to foreign substances, regardless of their eventual usefulness. They in turn become useful tools for research. For these studies of antibody reaction, the author prefers the word *serology.* He insists that we must confine our perspective of the entire field of immunity within the bounds of the activities of antibodies. The author therefore proceeds to describe the phenomena of *immunity* in basic terms, especially with reference to the body's resistance to bacteria, viruses, and toxins. This is about the most stimulating book your reviewer has run across this year.

Modern Concepts of Communicable Disease, by Morris Greenberg, M. D., and Anna V. Matz, R. N., ($6.20. *G. P. Putnam's Sons, New York 16, N. Y.).* The tremendous reduction in mortality and the increase in the life expectancy that have taken place within the lifetime of your reviewer have come about to a large degree through the wide acceptance of the work of the plumber and the iceman. It has been sanitation and refrigeration that have done so much to control the spread of communicable diseases. Quite correctly the authors of this text emphasize that DISease is in fact an imbalance between the agent on the one hand and the susceptible host on the other. To a much greater extent than we physicians often appreciate, this imbalance is determined by the patient's environment. Some 54 specific DISeases are considered in the text from this viewpoint.

Physiological Foundations of Neurology and Psychiatry, by Ernst Gellhorn, M. D., ($8.50. *The University of Minnesota Press, Minneapolis 14, Minn.).* In these days of dream books posing as scientific texts on abnormal psychology, it is most refreshing and helpful to have the physiological basis for mental processes reviewed and brought up to date. The author has integrated the clinical and experimental literature to give us an up-to-date picture of where we are today, the problems that remain, and an indication of the possibilities of future investigation.

Textbook of Preventive Medicine by Hugh Rodman Leavell, M. D., and E. Gurney Clark, M. D., with the collaboration of 19 contributors in the field of Public Health, ($8.00. *McGraw-Hill Book Co., Inc., New York 18, N. Y.),* approaches the subject from the epidemiologic angle. In your reviewer's opinion, it is ignorant of the routine of a busy physician's office and would place all too much responsibility on our shoulders that should be put on the school teachers. While all of us can help—the public health officer as he goes about his legitimate business of prevent-

ing the spread of communicable disease; the private physician as he goes at his daily task of relieving pain and suffering, stopping the invasion of his patient's body by germ, in supporting it and making temporary repairs as the body of his patient begins to fall apart prematurely—but the real job of education on how to keep one's health belongs to the educational system where there is time, personnel and teaching skills.

New Light on Dreams, by Max Serog, M. D., ($3.00. *House of Edinboro, 21 Edinboro Street, Boston, Mass.).* A new study of dreams and their interpretation by a noted psychiatrist. The author insists and with good reasoning that all dream phenomena are to be understood as manifestations of primitive thinking rather than as examples of the more popular current artificial and complicated theories.

Essential Urology, by Fletcher H. Colby, M. D., ($8.00 Second Edition. *Williams & Wilkins Co., Baltimore 2, Md.).* A text by the head of the department of Massachusetts General Hospital designed for the student and resident, and as an aid in preparation for the Boards. It gives a good clear picture of urology as it is practiced at MGH.

Ophthalmologic Diagnosis, Including a Primer of Ophthalmology, by F. Herbert Haessler, M. D., ($8.00. *The Williams & Wilkins Co., Baltimore 2, Md.).* The author brings a new approach. He considers the eye as a sick organ, the manifestations of whose disorders must be carefully collected and evaluated. As a good clinician he shows the reader how to weave the patient's story, the physician's own observations and the significance of all of the data into an integrated pattern.

Surgery of the Biliary Tract, Pancreas & Spleen, by Charles B. Puestow, M. D., Ph. D. (Surg.), ($9.00. *The Year Book Publishers, 200 East Illinois St., Chicago 11, Ill.).* Properly executed surgery has offered through the years increased comfort and happiness to countless patients. This text is intended for the surgical resident and for the trainee surgeon as a source of information and quick reference, and is not intended for the novice.

Nursing Arts, by Mildred L. Montag and Margaret Filson, ($4.50. Second Edition. *W. B. Saunders Company, Philadelphia 5, Pa.).* Contains 36 chapters on each and every phase of the art of nursing—the total care of the patient in the home and in the hospital. The role of the nurse as a teacher of health is stressed throughout.

The 1952 Year Book of Endocrinology, edited by Gilbert S. Gordan, M. D., ($5.50. *The Year Book Publishers, Chicago 11, Ill.).* With few exceptions, according to the editor, definitive endocrine diagnosis can be made from the evidence supplied by a careful history and a thorough physical examination. The emphasis is placed upon "the mere fact that the results of tests are reported in milligrams or milliequivalents does not prove sensitivity or specificity even if carried to the third decimal place." This same man has selected what are the important developments for you and me in his field for one whole year.

Introduction to Physiological and Pathological Chemistry, by L. Earle Arnow, M. D., ($3.75. Fourth Edition. *C. V. Mosby Company, St. Louis, Mo.).* In the careful revision of the text by Miss Marie D'Andrea of St. Vincent's Hospital in Indianapolis, Ind., a new chapter appears on Nuclear Reactions and Atomic Energy with special emphasis on disaster nursing.

Introduction to Laboratory Chemistry, by L. Earle Arnow, M. D., ($1.50. Fourth Edition. *C. V. Mosby Company, St. Louis, Mo.).* A laboratory manual designed to be used along with the author's text.

The Nursing Mother, by Frank Howard Richardson, M. D., ($2.95. *Prentice-Hall, Inc., New York 11, N. Y.).* Since it is well established that babies who nurse do resist infection ever so much better than bottle-fed babies, and grow with less intestinal difficulties, it is about time that someone in authority should give the expectant mother a readable book designed to help her enjoy the benefits and satisfactions of breast feeding. This work endorsed by Clifford Grulee and Nicholson J. Eastman is certainly well fitted to meet this urgent demand.

Clinical Management of Behavior Disorders in Children, by Harry Bakwin, M. D., and Ruth Morris Bakwin, M. D., ($10.00. *W. B. Saunders Company, Philadelphia 5, Pa.).* This volume is designed as a practical guide not only for the physician but also for the professional workers in the field of child psychology. It brings together the best information available on the psychological aspects of child care. If accepted as one tool in the armamentarium it can be most helpful. But if the physician mindful of his own failures drops all the rest of his armamentarium and clings to this because it absolves him from all responsibility, then the psychologic approach to childhood disorders can do much more harm than good. Used wisely this book can be of great worth.

Nervous Transmission, by Ichiji Tasaki, M. D., ($7.50. *Charles C. Thomas Co., Springfield, Ill.).* The author treats of the fundamental concept of nerve-impulse transmission; of the properties of the node of Ranvier; of the properties of the nerve fiber; of the effects of refractoriness, of narcosis, and electrotonus. In the appendix are the details of microtechnique of nerve fiber dissection.


They like it...

The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 50 March, 1954 No. 3

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Leprosy in Ohio and Report of a Case

FRANCIS W. EPSTEIN, M. D., and JACK C. BURNHEIMER, M. D.

NOTHING has been written of the epidemiology of leprosy in Ohio, due no doubt to the relative numercial unimportance of the disease in this part of the country. However, from time to time, as shown in the subsequent list of cases, occasional instances of leprosy do arise, and the physician should remain aware of this possibility.

Although leprosy was made a reportable disease in Ohio in 1920, records are not available prior to 1925. Since that date to the present 15 cases of leprosy have been reported, including the one being reported now.

CASE REPORT

Case Report (included in the subsequent table): No. 15, a 23 year old, single, Mexican male first consulted one of us (FWE) on October 19, 1951, because of an "itching" eruption on the buttocks, thighs and legs. He stated that he had been perfectly well until three to four months previously when he developed an eruption of both feet along with some painless swelling of the hands and feet. This cleared up, and it was impossible to ascertain the nature of these symptoms. Shortly after this he developed nasal congestion and discharge and occasional small epistaxes.

The first skin lesion made its appearance shortly thereafter and was noted as a painless red papule on the forehead. More lesions appeared on the cheeks, later spread to the ears, then to the left forearm, buttocks and thighs. Weakness of the left arm and leg were noted following moderate exertion, and numbness of the ulnar surface of the left forearm and left little finger developed.

Submitted May 11, 1953.

The Authors

- **Dr. Epstein, Toledo, is a member of the attending staff at Maumee Valley Hospital.**
- **Dr. Burnheimer, Toledo, is a member of the staffs of Maumee Valley Hospital and Toledo Hospital.**

Family History: The patient was born in Southstone, Texas, in 1928, and lived there all his life except for one year in California in 1948. He moved to northern Ohio about one and one-half years before he was seen by us. His parents were born in Mexico and moved to Texas about ten years before the patient's birth. His father died in 1938 of unknown cause. His mother and five siblings were living and well.

Physical Examination: The patient was a thin, 23 year old Mexican male. The face presented a somewhat ruddy appearance. Examination of the skin revealed a diffuse, confluent, brownish, maculo-papular eruption over the face, posterior thighs, buttocks and on the ulnar surface of the left forearm.

The ear lobes presented pea-sized, nodular, infiltrative, reddish lesions, and there was suggestive induration between the eyebrows. The nasal mucosa was edematous, reddened and there were serous discharge and blood clots present. There was anesthesia to pin prick and to hot and cold stimuli over the ulnar surface of the left forearm, hand and little finger and over the lesions on the buttocks and thighs. No lymphadenopathy was present. Examination of the heart, lungs and abdomen was within normal limits. All reflexes

were present, active and equal. No pathological reflexes were elicited.

Examination of the eyes is noted (courtesy Dr. Louis C. Ravin, Toledo, Ohio): "Biomicroscopic examination of the cornea reveals several areas of white opaque dots in the anterior corneal layers, arranged in clump-like formation about 2 mm. from the limbus, each eye. There is increased visibility of the corneal nerves. The entire cornea has a slightly opaque appearance. The corneae have normal sensitivity to light touch. The irides are normal. Both lenses are normal. The vitreous and fundi are normal."



Fig. 1. Photograph of Buttocks Showing Lepromatous Skin Lesions.

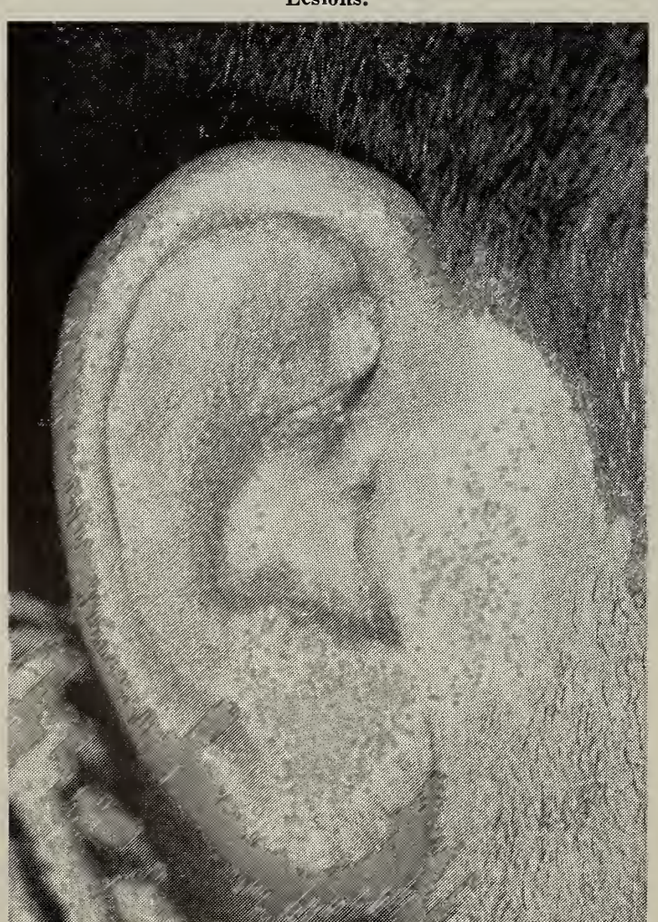


Fig. 2. Photograph of Ear Lobe Showing Nodules of Leprosy.

Laboratory Findings: Roentgenograms of the chest and of the bones of hands and feet were normal. The admission red blood count was 4,880,000, with 14.3 grams of hemoglobin. White blood count was 7,900 with 58 segmented forms, 4 stab forms, 27 lymphocytes, 8 monocytes and 3 eosinophils. Serologic test for syphilis was negative, Urinalysis was normal. Smears of nasal discharge revealed innumerable acid-fast bacilli.

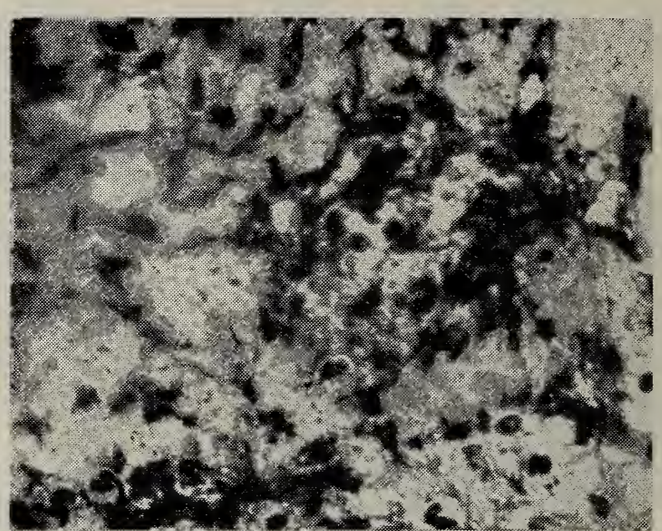


Fig. 3 Acid-Fast Smear of Nasal Mucosa Showing Many Clumps of Acid-Fast Bacilli.

The pathological report from biopsies of the ear lobe and thigh is as follows—(courtesy M. F. Vidoli, M. D., pathologist, St. Vincent's Hospital, Toledo, Ohio):

"The sections from both nodules from the ear and thigh present the same histologic appearance. The epithelium is atrophic but everywhere preserved. The underlying corium and subcutaneous tissue is replaced by a massive ingrowth of irregularly scattered, but closely set cells with finely granular, pale cytoplasm and small regular nuclei, usually placed eccentrically or near the cell border. Frequently the cytoplasm shows numerous small vacuoles, and occasionally is almost completely clear. A very small amount of fine collagenous fibrils is found in some areas separating the individual cells and occasionally thicker bands separate larger clusters of the clear cells. Acid-fast stain reveals a very large number of acid-fast bacilli arranged in clumps and present in almost every cell of the clear type just described.

"*Diagnosis*, nodular leprosy."

Hospital Course: The patient was admitted to the hospital on October 30, 1951, and discharged to the National Leprosarium at Carville, Louisiana, on November 11, 1951. Diasone® in a dosage of 0.33 grams daily was started on Nov-

ember 3, 1951, with no improvement noted at discharge.

DISCUSSION

The accompanying Table 1 presents the 15 cases of leprosy reported from Ohio (courtesy Dr. Charles R. Freeble, Jr., formerly, Chief, Division of Communicable Diseases, Ohio State Department of Health).

Of the 15 cases presented in table 1 nine were foreign born. Two of the American born patients were of Mexican parentage who were born in Texas, later migrating to Ohio. Of the remaining four American born patients one was born in South Carolina and one in Virginia, migrating to Ohio at a later date. Of the remaining two patients one (No. 8) served in the army in the Philippines and Hawaii for six years and may have acquired leprosy there. The other patient (No. 1) had an alias, and his origin is dubious. Thus it may reasonably be concluded that of the 15 cases of leprosy reported in Ohio since 1925, none were endemic.

As may be gathered from an historical review of leprosy throughout the world, many decades must elapse before the Hansen's bacillus can root itself in any region. Countries with a high degree of civilization and adequate hygienic precautions are not subject to a spread of leprosy, therefore leprologists are not too seriously concerned with the future spread of the disease in this country.

The most accurate surveys of the number of leprosy cases in the continental United States are based on actual admission of leprosy cases to Carville, Louisiana, from December 1, 1894, to June 30, 1948.[1] One thousand six hundred forty-one patients were admitted with distribution according to states as follows:

Louisiana	628, or 38.3%
Texas	250, or 15.2%
California	243, or 14.8%
Florida	87, or 5.3%
All others	433, or 26.4%

Of the total number of patients admitted 60 per cent were natives of the continental United States.

As of June 30, 1948, there were 400 patients in the hospital at Carville. Their distribution by states was as follows:[1]

Texas	102, or 25.6%
Louisiana	92, or 22.8%
California	70, or 17.4%
Florida	42, or 10.4%
All others	93, or 23.8%

According to estimates, the number of unknown lepers in the United States ranges anywhere from 500 to 5000.[1] The states of Louisiana, Florida, and California show a tendency to decreased incidence. In Texas where a high degree of Mexican migration occurs, cases appear to be increasing. Immigration labor groups from areas of high leprosy incidence will bring an occasional case into the Northern states, such as happened in the case reported herein.

It is this occasional exotic case of leprosy which demands that the physician retain an index of suspicion for the patient who may have migrated from an endemic area. Unusual dermatological lesions and neurological manifestations consisting of paresthesias and peripheral nerve sensitivity should alert the physician to the possibility of the disease. Once the physician suspects the disease, diagnosis remains simple in most instances.

Acknowledgment: We are indebted to Dr. Bernhard Steinberg, pathologist, Toledo Hospital, Toledo, Ohio, for preparing the photomicrographs and to Dr. John C. Kelleher, Toledo, Ohio, for the photographs.

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TABLE 1. FIFTEEN CASES OF LEPROSY REPORTED IN OHIO FROM 1925 TO 1951

Year	Number	Sex	Age	Color	Location	Birthplace	Parentage
1925	1	M.	51	W	Cincinnati	U. S. A.	American
1927	2	F.	25	W	Martins Ferry	Greece	Greek
1932	3	F.	22	W	Steubenville	Foreign born	Foreign ?
1937	4	M.	45	W	Martins Ferry	Greece	Greek
1938	5	M.	69	C	U. S. Marine Hosp. Cleveland	Virginia	American
1938	6	F.	49	W	Steubenville	Greece	Greek
1942	7	M.	39	W	Toledo	Mexico	Mexican
1942	8	M.	60	W	Dayton	U. S. A.	American
1944	9	M.	42	Yellow	Cleveland	China	Chinese
1047	10	M.	12	W	Steubenville	Italy	Italian
1947	11	F.	39	W	Steubenville	Italy	Italian
1949	12	M.	59	W	Newton Falls	Italy	Italian ?
1951	13	M.	55	W	Port Clinton	Texas	Mexican ?
1951	14	M.	55	C	Akron	South Carolina	American
1951	15	M.	23	W	Toledo	Texas	Mexican

Treatment of the Allergic Child: What Parents Should Be Told

HAROLD A. ABRAMSON, M. D.

THERE are more than ten million people in the United States who have allergic complaints of one kind or another. A comparatively large fraction of this group of allergic people are infants and children who often are retarded in their physical and mental growth, because of allergic reactions to foods, inhalants, and even to medicines. Some of the children mature too early and are, therefore, resentful of the way their illness makes them deal too soon with life's difficulties.

It is always problematic for parents to decide just what the proper course of treatment of the allergic child should be. Very often the parents are told, and too often believe, that the child "will outgrow the allergy." Perhaps, just as dangerous for the welfare of the child as this type of unjustified conscious neglect of an illness is the demand by the parents from the physician that the child be cured of what is often really a constitutional inherited state in the child. In this way the doctor is called upon to perform a miracle which is not in the sphere of his function for the allergic state is genetic in origin.

DECISION ON TREATMENT

Just how then, should parents decide how the allergic child should be treated? There is a good deal of controversy on this point. On the one hand, there is the organic, or physical or somatic point of view steadfastly maintaining that the allergic child can easily be handled by physical measures like control of diet, diminished exposure to inhalants like dust and the administration of certain medicines.

The other point of view, which I have encountered is that it is "all emotional" and that all one has to do is establish within the home a suitable psychological milieu. Once the home environment is desensitized so to speak, of emotional conflicts, the constitutional allergic factors which give the child eczema, hay fever or asthma will disappear. We must consider and understand the basis of both points of view.

It is important at the outset to recognize that the allergic child, although sick or potentially severely ill, does not have a contagious or catching disease. Certainly, virus and bacterial infections may initiate or be superimposed upon the allergic reactions but the eczema of the child is not catching nor is asthma infectious or contagious. This knowledge will remove at least one source of anxiety which is frequently encountered.

Submitted June 5, 1953.

The Author

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On the other hand, allergy is an illness and a serious illness which affects not one particular system of the body the way heart disease does, for example, but it affects all of the tissues of the body.

Thus, when the skin is allergic we have allergic dermatitis and eczema; in the eye, allergic conjunctivitis and allergic iritis; in the nasal passages allergic rhinitis or hay fever with its complication of sinusitis. In the throat, allergic pharyngitis and laryngitis arises and as the process extends down the air tubes, allergic bronchitis and asthma may occur.

Spastic allergic phenomena in the intestinal tract are very common in infants and children. Allergic reactions in the blood vessels, in the kidneys, in the liver, in the heart as in rheumatic fever, as well as in the central nervous system, are of importance. Indeed, in many infectious diseases, as for example in tuberculosis, the tissue response is an allergic reaction. Therefore, the physical aspects of allergic tissue reactions cannot be underestimated.

ROLE OF NERVOUS SYSTEM

But do the tissues of the nose, of the lungs and of the skin and other organ systems react by themselves in an isolated fashion? That is, does the skin alone react with an allergic dermatitis? Does the nose react with hay fever and the lungs with asthma connected perhaps, only casually, with the central nervous system?

Even if there were no cortex of the brain, no emotions in the child and no unconscious fears, indeed, it would be difficult enough to study and treat allergic children without the influences of the nervous system itself, that is, without the effect of the neuromotive and psychomotive forces at play. However, not only are all the tissues of the body connected with the central nervous system including those parts which have to do with feelings but also the allergic child has to deal with the attitude of his mother and of his

father toward his illness and, therefore, toward the child himself.

So, in order to understand and treat allergic illnesses in children we must not only understand the nature of the way in which the tissues in the child react to allergens but we must also work out in what way, if possible, the child himself is made anxious by his allergic illness and how his illness affects the attitude of his parents toward him. In other words, the treatment of the allergic child is always connected in one way or another with the emotions of the parents; how they are able to deal with their own attitudes, for example, toward the wheezing, sickly, asthmatic child or the child with the intractable eczema who despite all medical care or parental attention persists in scratching to the distraction of the entire family.

Let us first take up some facts connected with certain misconceptions which are often met and attempt to clarify the situation so that the parents of the allergic child may make a more complete utilization of our knowledge today.

Let us consider the facts of the basic physiological notion in allergy: The body is hypersensitive. The question arises, hypersensitive to what?

ARE SKIN TESTS NECESSARY?

One of the ways of finding out what the body is hypersensitive to is by means of a series of skin tests. There are different ways of doing skin tests and it is beyond the scope of this discussion to describe the best type of skin test for each patient. That is the doctor's job to determine. However, except for very young children, the skin tests form an important part of the study of an allergic hypersensitivity whether or not emotional factors are especially involved.

There has been a trend recently, amongst certain physicians, to disregard the results of these important immunologic findings. No doctor studying the heart would say that a study of the blood pressure and the electrocardiogram was not helpful in determining the status of the heart musculature and blood vessels. So, no doctor with a thorough understanding of the immunologic basis of allergy would say that the skin tests were unimportant. So as far as the skin tests are concerned, if the doctor decides that the skin tests will be useful, they should be performed in spite of the misconception that they are not valuable.

HOW SHOULD SKIN TESTS BE USED?

Does a positive skin test mean that the patient must be treated by injections of the material which react positively? The answer is "no." The skin tests, like any other laboratory procedures are guides. It is certainly not necessary to give injections of food extracts to which the patient is sensitive. Most specialists in allergy agree with this point of view. However, too often commercial houses who receive prescriptions from the results of skin tests are apt to include foods in the material for desensitization. However, if a food acts as an inhalant, then the child should be given an injection of the extract of the food, as in the case of wheat flour.

In the case of many substances which children inhale such as the dust of feathers, dogs, cats and all of the things which are found about the farm or the dressing room, elimination is the more rational procedure. However, some substances are unavoidable—the pollen, the mold spores, dust and certain of the danders. A dust extract made from the home of the patient where there is a cat, may include enough cat dander perhaps, to build up a certain amount of tolerance after a course of injections.

Even though the child is skin reactive to certain foods, it is not always necessary that the food be avoided entirely. In the case of young children, test diets, the results of which are carefully scrutinized by the physician, help in determining which of the foods are most important in producing the clinical picture. Certainly, this is nearly always true that in the case of the allergic child: no one thing is responsible for the symptoms. There is no single antigen, no single responsible substance. The allergic child is usually responsive to many things, including some things for which we cannot skin test such as certain types of infections. For this reason, the skin tests should be used as guides to ascertain which positive reacting materials are of importance in the production of symptoms.

It is important to remember that a positive skin test need not necessarily indicate a present symptom but may portend a future symptom. Very often children with no symptoms at all during the ragweed season will react to ragweed extracts. Whether or not this child should be treated prophylactically at once with ragweed extract, is a controversial point in medicine today. But there is no controversy amongst allergy specialists that the positive skin test to ragweed whether or not the child has ragweed symptoms means that the child is a potential patient with possible future ragweed hay fever and asthma.

Even if all of the skin tests are found to be negative, it does not mean that the symptoms of the child need not be allergic. Negative skin tests merely mean that the substances to which the child has been tested are negative but there are many substances producing allergic responses for which skin tests have not been worked out. This is especially true in cases where the children are sensitive to the products of their own bacteria or viruses. Certainly, one of the most difficult problems in the management of the allergic child is to ascertain what causes asthma before, during or after a respiratory infection.

As a matter of fact, many substances rarely produce positive skin reactions and yet the most violent types of allergic phenomena may occur.

The simplest chemicals are guilty in this respect. Allergy to aspirin, phenolphthalein, penicillin, and other substances do not give the same type of positive skin tests with the same significant results that are found in tests with the larger protein molecules in extracts of food stuffs which are so important in young children.

One of the errors frequently encountered in the interpretation of skin tests is the child who reacts to everything. When a child reacts to everything this is not an allergic response to the substance being tested. In the experience of the writer it is due to dermagraphism, or a response to the mechanical strain of the skin being injected or broken. In general, if there are too many positive reactions, the whole way in which the skin tests are done should be scrutinized in view of the possibility of the presence of dermagraphism.

THE PATIENT AS A WHOLE IS TREATED

It is important that the doctor himself, after scrutinizing the skin tests evaluate for the parents the meaning of the skin tests in terms of the actual habits of the child rather than in terms of the skin tests themselves. The patient as a whole should be treated, not the positive skin tests. A predetermined schedule of desensitization or a diet based exclusively upon the results of the skin tests is not desirable. The reaction of the children and of the parents must be considered in this connection.

Some of the problems which I should like to have solved is what to do with dogs and cats in country homes. Certainly the doctor's position is that animals should be removed at once; but what are the psychological effects of removing a loving friend upon the child and upon the parents? Sometimes compromises are necessary. The dogs may be kept outside and not allowed in the bedroom. Injections by autogenous dusts including some dander may be of value.

SHORT-CUTS TO "CURE"

One of the most serious problems of this day and age is the effect of radio and other forms of promotion on the attitude of the parents toward the search for a short course of treatment or a cure. In a case of asthma in children newer antihistaminic drugs are of very little benefit compared with the older types of antihistamines like ephedrine and epinephrine. The newer antihistamines are not to be trusted in certain crises occurring with the allergic patient. Irrespective of their alleged value, none of these drugs do away with the need for the doctor to treat the patient from a point of view of allergic sensitizations and of the emotional factors involved in the total situation.

The same applies to cortisone and ACTH. These drugs do not eliminate the need for suitable management of the allergic child and for understanding and insight on the part of the parents. Dramatic results obtained are temporary. Please remember that new ideas and new methods of treatment need not necessarily be best. They should be employed by the expert and the family of allergic children should consult the expert in an attempt to understand the physical and the mental processes present in the child and not look for dangerous shortcuts.

Above all it is extremely important to avoid habit-forming drugs such as narcotics. I do not think that the barbiturates fall into this category. However, morphine and similar compounds like meperidine, and substances related to opium should never be given to the allergic child except in an extreme need in the judgment of the physician.

PHYSICAL THINGS TO REMEMBER

There are certain facts on the physical side that are wise for parents to keep in mind. Keeping these in mind, will help the doctor organize his therapy and facilitate his recognizing the emotional side of the picture. For, unless the physical side of the picture is well understood by parents and child, analysis of the emotional side is fraught with the danger of neglecting the physical.

Remember that pollen grains are primarily the cause of most summer hay fever. Anything that will decrease the exposure of the child to pollen is important. Air conditioners are useful if temperature changes do not bother the child. Do not go driving during the pollen season in open cars.

Animal danders are extremely important allergens as well as feather pillows and all furniture dusts.

Paints and many other irritants may not alone primarily irritate the nose, but also may add to the injury of an already inflamed mucous membrane of the nose and lungs.

During the hay fever season, electric fans should if possible be used cautiously, not only because the temperature changes rapidly but because more pollen and more dust is blown at the patient.

Iced drinks set up reflexes in the nose and throat. These reflexes may produce asthma during the pollen seasons and all the year round as well.

Doctors may advise you to eliminate certain foods especially chocolate, spices, wheat, milk, citrus juices, fish or, in general, sea foods. All of these foods may produce—especially in children—physiologic and immunologic responses, and may be the primary cause of eczema, hay fever asthma, urticaria and in addition allergies like gastrointestinal allergy.

MENTAL THINGS TO REMEMBER

It would be very simple if the tissues of the nose, the lungs, the skin and other organ systems, reacted by themselves. That is, if the emotional attitudes of the children and of the parents, didn't come into the picture by increasing the intensity of the clinical reaction. That is, even if we were to assume that there were no cortex

of the brain, no emotions, no unconscious conflicts, it would be difficult enough to study carefully the immunologic phenomena of allergy without the influence of the nervous system, and without the effects of these inner feelings. However, all of the tissues of the body are connected with the central nervous system, including those parts of the central nervous system which have to do with feelings, inner stresses and unconscious conflicts. So, in order to understand fully the allergic response in children, we must understand not only the way in which tissues react physically and chemically but, we must also work out if possible, how the nervous system and its emotional responses change these reactions.

What is meant by an "inner stress" or "unconscious conflict"? This is a difficult concept to understand because it isn't anything that is measurable in ordinary terms. One can't weigh out a pound of anger, a quart of hostility or an ounce of frustration. These are feelings and can only be transmitted to us by words which very often have different meanings for different people. And, these inner stresses are what are technically called "unconscious conflicts." It is these unconscious feelings and stresses in both parent and child which can intensify the allergic phenomena of the child, which make a simple case of asthma a complicated one, which transform a mild case of gastrointestinal allergy into a severe one, and, which cause difficulty both in diagnosis and in treatment of the eczemas.

Let me illustrate how inner feelings may influence the course of allergy in a child and how recognition of the role played by mental stresses may lead to a happier outcome:

An eight year old boy with very severe asthma was often hospitalized for no reason obviously allergic, two or three times a year, placed in an oxygen tent and after a week or so returned home. However, the skin tests for allergy, in and of themselves, could not account for the severity of his asthma.

On going into his history in more detail it was ascertained that his mother and father had been divorced and the boy was living with his mother and stepfather. The mother had very strong guilt feelings concerning the circumstances under which she had left her first husband, the father of the child, even though her second marriage was happy and a good home had been set up for the boy. The fact that the mother had now provided a good home for the boy, did not completely eliminate the many guilt feelings that she had in regard to the dissolution of her first marriage.

In an attempt to secure her second marriage she had neglected her son to a certain extent. She felt that his illness and the expense of his illness was endangering her position with her second husband. After some discussion she gained some insight into her rejection of her son, and understood more clearly her own feelings of guilt connected with her role in breaking up her first marriage. Thereafter, she was able to establish a better relationship with her son.

As this gradually took place fewer medicines were needed. The mother's attention and love for the child could be expressed without the overshadowing feeling of hostility and guilt which she had in relationship to the boy's father and which were extended to a certain extent, in the past onto the son. The boy's relationship with his mother and stepfather as well as with his own father improved as his mother could express her love for him without an admixture of guilt. The drugs usually efficient in asthma soon worked again and it was no longer necessary to hospitalize him at all. As a matter of fact he ultimately lost most of his asthma. This boy was an allergic child, sensitive to ragweed and as it turned out he was a typical case of pollen asthma where the emotional stresses prolonged and intensified his illness to a dangerous point.

To summarize, any allergic symptom, such as asthma, hay fever, hives, and eczema always must have two sets of factors producing the symptoms. The first set are the physiologic factors (immunologic factors) and the second set are the psychologic factors. We can think of the allergic symptoms as forming the hypothenuse of a right triangle with the allergic or physiologic factors, the base, and psychologic factors the other vertical side.

There are fluctuations in the relative role of the importance of each of these physiologic and psychologic factors, depending upon the life situation of the child, his anxieties, the life situation of the parents, their anxieties, the number of pollen in the air, as well as other allergens. For example, the symptom may be almost totally dominated by psychologic factors, with very few of the physiologic factors present or vice versa. As mentioned, one of the difficulties in studying the effects of inner stresses and unconscious processes is in the essentially unmeasurable nature of feelings.

It is easy for anyone to see how to measure the skin sensitivity to ragweed pollen extract but it is very difficult to determine just how much hostility is present in this situation or how much guilt in that situation and how much rejection of children by parents exists during the medical treatment of any allergic child. We deal with unmeasurable factors, unmeasurable feelings which must be conveyed by a special language of communication from one person to another. And, this communication itself must not produce anxiety. We all know that the process of understanding inner stresses is usually threatening in and of itself, so it is very difficult for the doctor to explain and the parents to accept in what way their relationship with their allergic child may be threatening and therefore threatening to the effective treatment of his allergic illness.

Pseudo-Anginal Pain as an Epileptic Equivalent: Case Report

GERALD E. MEYER, M. D., and OLIVIA F. GANDER, M. A., R. R. L.

AN epileptic seizure is the result of an abnormal focal ganglionic discharge which may manifest itself in a bewildering variety of phenomena, many of which are seemingly unrelated to the "falling fits" of antiquity. Three main patterns of seizures are recognized: (1) grand mal, which is characterized by convulsions; (2) petit mal, characterized by a brief lapse of consciousness, without convulsion; and (3) psychomotor equivalents, which may be accompanied by either a convulsion, a loss of consciousness, a combination of the two, or by neither.

Psychomotor epilepsy may be exceedingly difficult to recognize. One consistent diagnostic sign is the recurrence of the seizure over a long period of time. Another is the lack of demonstrable organic lesion of sufficient importance to account for the patient's manifestations of distress. A third but more variable sign is the patient's amnesia for much or for all of each episode.

Clinically, the appearance and behavior may so strongly suggest intoxication that the patient is picked up by the police. If he is promptly hospitalized, the diagnostic impression is likely to be either hysteria, acute abdomen, carotid sinus syncope, anginal syndrome, or some other cardiac condition, depending upon the presenting symptoms. If several diagnostic tests are given, their failure to disclose an accountable organic lesion may result in erroneously consigning the case to psychiatry. Seldom is epilepsy suspected.

Though the epileptic equivalent, or "aberrant epilepsy," may appear in the guise of any one of innumerable acute conditions, only rarely has it been recognized and reported when masquerading as the anginal syndrome. One such case came to our attention on medical service at Miami Valley Hospital, Dayton, Ohio.

CASE REPORT

On the night of Feb. 18, 1953, a white male, who later gave his age as 72, was brought to the hospital by police ambulance after he had apparently collapsed and become comatose on a downtown street. When seen in emergency ward he had roused and was complaining of severe, sharp, substernal pain radiating into the left neck, halfway up to the angle of the jaw, and down the left arm to the fingertips. He also complained of minimal precordial pain and shortness of breath.

He was immediately given oxygen by mask. Within ten minutes he was almost entirely free from pain and was no longer dyspneic. He then vividly described his recent symptoms and began to relate his history. But in a few minutes his narrative was interrupted by a return of the severe substernal pain, radiating as before. Again he was given oxygen. An electrocardiogram taken at the height of the attack showed nothing remarkable to account for his great distress.

At this time it was noted that opisthotonos was present and the eyes were glassy and rotated backward. Pain stimuli were promptly applied, but he gave no response to pinpricks on various areas of the body, pressure on the supra-orbital notch, or twisting and pinching folds of skin. There was no fecal or urinary incontinence.

The attack subsided within a very few minutes, but during the next half-hour there were several similar episodes. At the end of that time the patient became completely relaxed and no longer complained of any chest pain whatsoever. He was totally unable to recall any part of the conversation during which he had first described his symptoms and begun to relate his history. The only memory he retained of an episode lasting slightly over an hour was a hazy recollection of being moved from one room to another.

History: Later questioning of the patient revealed that he had been experiencing such attacks for 55 years, since the age of 17. Due to a rather unusual educational background he was able to give a lucid and detailed account of his symptoms.

According to the patient's recital, his typical attack gives no warning whatsoever. Everything suddenly "goes black" in front of his eyes, and then the severe stabbing pain begins. It is chiefly substernal, but extends one or two cm. to the left of the sternum and radiates upward into the left neck, to the left shoulder, down inside the left arm to the elbow, and down the outside of that arm to the fingertips. Within a minute or two after the pain begins he loses consciousness. When arousing from his coma he notices some residual pain of the same type and distribution as that which initiated the attack, but much less severe in quality. His chief sensation is one of extreme fatigue. He has complete amnesia for the major part of the episode, and frequently is unable to recall events immediately before and after the seizure.

At first these episodes occurred only one in three or four months, and were so light and brief that no medical attention was required. They gradually increased in frequency, duration, and severity, and in 1945 the patient suffered his first prolonged attack while on the streets of Chicago. He was promptly taken to a hospital, where a diagnosis of angina pectoris was made.

Submitted September 25, 1953.

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Thereafter he was hospitalized repeatedly, in several cities.

Many electrocardiographs were made, but never during an attack until the present admission. At one hospital an electrocardiograph was made every hour for a period of 24 hours following an attack, without disclosure of any abnormality. During these various hospitalizations his condition was repeatedly diagnosed as angina and occasionally as carotid sinus syncope, but he was never told that he had a convulsion. By 1952 the attacks had increased to the rate of one nearly every month, and during the past year they have left him with a numb, tingling feeling in the left hand.

The patient has been unable to relate the onset of an attack to any particular item, except the drinking of two or three bottles of beer. Even this association is inconstant, in that such indulgence is not usually followed by an attack. However, he remembered that almost every episode, from youth onward, has been preceded within the hour by the drinking of moderate amounts of beer.

He has had the usual childhood diseases, and bronchopneumonia in 1930, all without sequelae. He has had no surgery and no known trauma. He suffered from moderately severe frontal headaches until 1947, when his teeth were extracted, and occasional mild headaches since that time. During the past ten years he has had occasional paroxysmal nocturnal dyspnea, one to two pillow orthopnea, and true mild exertional dyspnea, but no pedal edema and no known hypertension. He has experienced occasional episodes of sharp, stabbing pain below the right costal margin, about three cm. to the right of the midline.

Physical Examination: When the patient was brought to the emergency ward the temperature was 98.4°F., pulse 112, and blood pressure 100/70. At the time the above history was taken the temperature was 99°F., pulse 84, and blood pressure 110/70. Examination by systems, including neurological, was non-contributory, and all findings were within normal limits, except as follows:

EYES: Pupils constricted to about 1½mm.

ABDOMEN: Liver, kidneys, and spleen not palpable. There was point tenderness in an area about the size of a fifty-cent piece, below the right costal margin, approximately 4 cm. to the right of midline.

GENITALIA: A slight indirect inguinal hernia was found on the right; the left ring was minimally enlarged.

Laboratory Examination:

BMR: Basal metabolic rate on Feb. 28 was —28.

SEROLOGY: Negative.

BLOOD SUGAR: Fasting, 99.5 mgs. per 100 ml.

CHEST and upper gastrointestinal roentgenograms on Feb. 20, contributed no information except equivocal evidence of possible duodenal ulcer, to be interpreted as an accidental pattern in the absence of clinical symptoms.

ELECTROENCEPHALOGRAM—on Feb. 19, reported as normal 16 lead, with no evidence of focal or paroxysmal disturbance. Normal response to hyperventilation.

ELECTROCARDIOGRAM—on Feb. 18, taken at the height of an attack, was summarized as follows: "Changes are suggestive of myocardial damage on basis of arteriosclerotic cardiovascular disease, although there are no specific changes of old infarction or active myocardial changes noted."

Repeated on Feb. 24, with similar summary: "Abnormal ECG. Compatible with arteriosclerotic cardiovascular disease, without evidence of recent myocardial infarction in serial tracings."

Diagnosis: Because of the history of repetition of these attacks, beginning in late adolescence and continuing with gradually increasing severity up to the present time, because of the appearance of opisthotonos, and because of the lack of demonstrable organic lesion of sufficient importance to account for the symptoms, aberrant epilepsy was suspected. It was concluded that the abnormalities of the electrocardiogram were perfectly consistent with the age of the patient, but failed to account for episodic pain experienced since the age of 17.

Treatment: The patient was not given any anti-convulsant therapy while in the hospital because the case was regarded as a diagnostic problem and it was preferred to study the manifestations of the disease unmasked by medical control.

Hospital Course: During his eleven-day stay in the hospital he did quite well, except for one brief attack of pain, with "blacking out," on Feb. 22, while lying quietly in bed. Examination within a few minutes after onset of this attack showed the pulse to be slow and regular, the lungs and heart clear.

He was discharged on March 1, and instructed to take dilantin,® 1½ gr. three times a day, and phenobarbital, ¼ gr., four times a day.

Subsequent Course: Thereafter the patient was seen briefly in emergency ward on six separate occasions, and it was learned that he had completely disregarded medication.

Usually he was brought to the hospital by police ambulance. At one time he was found in dangerous proximity to a railroad track in a sparsely settled area, and it is probable that only the happenstance of a cruising police car saved him from accidental death.

On each appearance in emergency ward he manifested opisthotonos and complete anesthesia for pain stimuli, if seen during the height of an attack. Sometimes, however, he apparently passed the peak of the attack during transit, and reached the hospital in a stupor of fatigue. Amnesia for the period of the attacks persisted.

DISCUSSION

In this case it is interesting to note that a diagnosis of epilepsy had not previously been made. Since the patient had no knowledge of his opisthotonos, and since that condition was not observed during the first attack we witnessed but was noted during all subsequent attacks that came to our attention, it is probable that it was manifested for the first time during this period of hospitalization.

Another factor delaying the diagnosis was the dramatic obviousness of the anginal symptoms. Intense substernal pain, radiating to left arm, shoulder, and neck, is so thoroughly associated with the anginal syndrome as to seem pathognomonic. In this case its presence almost obscured certain other signs of great significance:

(1) Onset during late adolescence;
(2) Attacks precipitated by intake of alcoholic beverage;
(3) Consistent amnesia for the greater part of each episode.

A final argument against angina was the electrocardiogram taken at the height of an at-

tack, which failed to reveal any startling abnormality. Yet it was not until the appearance of opisthotonos that a diagnosis of epilepsy was suggested.

There is increasing evidence that a severe disturbance in the function of any organ, if not referable to organic lesion, may be attributable to paroxysmal cerebral dysrhythmia. In American medical literature of the past decade we have found three cases of varied visceral symptomatology reported by Winans, each of which proved to be a manifestation of epilepsy.[1] Fischer reported two cases of epilepsy in which severe paroxysmal cardiac pain was the only prodrome.[2] Furthermore, there is a spreading recognition of abdominal epilepsy as a clinical entity.[3, 4, 5]

Lennox has commented on the difficulty of differentiating the epileptic equivalent from hysteria, malingering, or psychosis, unless a fortuitous encephalogram demonstrates a spike focus from a temporal area.[6] Reminded that various studies have reported normal tracings in from 15 to 25 per cent of patients with undoubted epilepsy, we become more intensely aware of the problems of differential diagnosis.[7]

The possibility of aberrant epilepsy should be considered whenever paroxysmal symptoms recur over a long period of time without demonstrable organic lesion.

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The Irritable Colon Syndrome

The etiological factors involved in the production of the irritable colon syndrome usually fall into one of two main groups, namely, psychogenic or abuse of the digestive tract. This was evidenced in a review of 1,000 cases of irritable colon by Dr. Sara M. Jordan in which 62 per cent showed a combination of the above two factors and in 38 per cent of the patients there was no associated nervous factors, only abuse of the digestive tract by the long continued use of cathartics and enemas. In addition to the above, upper respiratory tract infections and various constitutional factors play their important role in the individual case.—Edward J. Donovan, M.D., Denver: *Rocky Mountain M.J.*, 50:952, December, 1953.

KEEPING UP WITH MEDICINE

• IN THE USE of medicines which are destructive to the mirco-organisms in the gut of the patient, we must not loose sight of the importance to the patient of vitamins which these organisms either synthesize themselves or help to synthesize. We should make it our business to re-establish the normal flora as soon as our round of medication is over. This is especially true of the "sulfa compounds" and the antibiotics.

* * *

• THE LARGE-SCALE experiments on man which are needed to solve the problem of optimal requirements of vitamin C have not been conducted. Our National Research Council recommends 75 mgms. per day which some say is an uneasy compromise between the intake comfortably preventing scurvy (30 mgms.) and the dose allowing saturation (100 mgms.).

* * *

• IT SEEMS that the usage of vitamin C is increased during infections, attacks of allergy, and under certain stress conditions, and when certain substances are ingested in larger than usual quantities. Of course, saturated tissues would automatically meet these increased demands. At the same time there is no evidence that saturation is in any way disadvantageous. It can therefore be argued that saturation should be aimed at in a conservative dietary policy. This would take about a dollar's worth of ascorbic acid as supplement. Certainly, saturation with natural vitamins should be considered in the patient with chronic infections and chronic allergies —such as the asthmatic.

* * *

• IT IS very likely that vitamin C is more or less specifically concerned in the oxidation of a precursor to the adrenal cortical steroid resembling cortisone or compound F.

* * *

• IN THE LAST decade there has been a shift of interest from vitamin C as a nutrient to vitamin C as a metabolite with hormonal and enzymatic relationships.

* * *

• THE PROCESS of emotion results in the activation of the hypothalamus which in turn discharges upward and downward. The downward discharge involves not only the sympathetic system but the parasympathetic system as well. The former activates the adrenal medulla and the latter the islands of Langerhans.

The upward discharge activates a normal cortical activity that not only holds in abeyance the downward discharge from the hypothalamus but also the upward discharge itself.—J. F.

Some Observations on the Role of Parents In the Emotional Growth of Children

CHARLES BOHNENGEL, M. D.

IN democratic cultures major responsibility for the promotion and measurement of the physical and intellectual components of personality growth has been assumed by our health and educational systems. At the same time responsibility for fostering the individual's emotional growth has been left to family, church and the first few years of school. This is as it should be, but it is evident that parents, as the principal preceptors in the school of emotional growth are in need of a more systematized form of guidance.

The psychotherapist is frequently called upon to offer such guidance to parents. Not only does this serve as a sort of preventive psychiatry for the child, but it also advances the psychotherapy of the parents by re-orienting them to their main function in life. Discussions with young mothers and fathers along these lines seem to be most effective when they are kept as simple as possible.

For the benefit of the young parent the emotional component of personality may be defined as that part which has to do with our feelings about and with others, our feelings about ourselves, about material things and about abstract concepts such as spiritual experiences, morals, principles and moods. It is by means of one's emotional make-up that both physical and intellectual activity are regulated and directed, thereby enabling the individual to participate either constructively or destructively in the lives of others.

EARLIEST EMOTIONAL REACTIONS IMPARTED BY MOTHER TO CHILD

During pregnancy and at birth, both parents will have already established an emotional attitude which will play an important role in the future life and happiness of their child. A few hours after birth, the infant is back with his mother, this time in her arms ostensibly for the purpose of nursing. What is especially important however, is that this represents the beginning of what is to be his first permanent and intimate emotional relationship with another human being.

If the mother, herself, feels secure and contented in her relationship with her husband and is joyfully accepting the new baby, irrespective of its sex, her arms and body will feel relaxed and secure to the baby. As she cuddles and nurses him she will impart through her confident, relaxed muscles the feeling of security and contentment which she herself experiences. It is by means of this shared experience with its mutually gratifying emotional reactions that the mother will have begun to participate intimately and constructively in the life of her child.

By contrast, the nursing infant whose mother is insecure or unhappy in her marriage or who is repressing resentment for an unwanted child may be brought to breast abruptly by tense, jerky muscles and just as abruptly popped back into the crib as soon as the nursing is over. There is apt to be a lack of joy and reassuring words or songs in the mother's voice. After such an experience the infant may very well have received anxiety or resentment rather than security and happiness from contact with the mother. In any event, whatever emotional reaction is imparted to the child it will tend to find a place somewhere in the child's eventual personality make-up.

It is not being suggested here that these early experiences with mother, and, as we shall see, also with father, alone determine the course of the child's future personality development. These experiences are stressed simply because they constitute the infant's first lessons in emotional growth. As such, they not infrequently, are representative of the pattern of family life to come.

MUTUAL FEELING OF GUILT

A fundamental fact for parents to learn is that it is the pattern of life, the trend, and not merely isolated events which influence personality development the most. Even a violent outburst of anger on the part of the harassed parent against the child can usually be constructively counteracted if the parent will have the courage to share with the child the mutual feeling of guilt which usually follows such an encounter. This is

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Read before the annual meeting of Ohio Psychiatric Association, April 21, 1953, Cincinnati, Ohio.

done best by means of a sincere, straightforward discussion with the child which clears the air and forms the basis for a new start between them.

Children, as well as immature adults, usually accept criticism of an isolated phase of behavior as if it were a sweeping rejection of the entire personality. In disciplining a child it is important for the parent to make it clear to the youngster that it is his manifest behavior and not his personality or underlying motivations which are being rejected. This fair-minded distinction on the part of the parent enables the child also to distinguish between the two and eventually to separate undesirable behavior from his personality.

With toddlers and infants, too young to understand the meanings of words, the mother's reassuring embrace and tone of voice convey to the child her love for him in spite of her resentment of his behavior. This will rescue the child from the feeling of being rejected simply because some phase of his behavior has proven undesirable.

As an example of a parent who learned to share her feelings of guilt with her daughter, let us consider Mary, age 10, and her mother. It seemed to Mother, who also had three other younger children and a large house to care for, that, for weeks, Mary had been giving her a "bad time." Tension between them had been high for days. It seemed to Mother that she was forever scolding and screaming at Mary; that, in spite of her every effort, Mary had become increasingly uncooperative in doing her share around the house.

Usually, after one of her outbursts Mother was inclined to turn her emotions inward and to feel sorry for herself so that nothing constructive was done about their difficulties for a long time. Occasionally, following one of these episodes the mother noticed, in herself, a fleeting sense of guilt which was mixed with her other emotions.

Finally, after an unusually difficult encounter, Mother, quite spontaneously and as much to her own surprise as to Mary's went to Mary and said, "Mary, I shouldn't holler and scream at you the way I do. I don't know why I do it. I don't want to do it but something just comes over me and I just can't seem to help it." Mary came closer to her mother, the harsh, resentful expression which she had had for days disappeared and she said, "Aw Gee, Mother. That's all right, I guess you must just be tired."

This was not the end of Mary's troubles with her mother but it proved to be the beginning of the end. Both had learned something from this experience. Mother had learned how to share her feelings of guilt with her daughter and Mary had gained an increased sense of her own worth by having been temporarily accepted on an adult level by her mother's appeal for understanding. As time went on their relationship was punctuated more and more by a frank sharing of one another's feelings. In this manner their encounters gradually became less frequent and their relationship more mature.

THE ROLE OF THE FATHER

Father, too, is important. We have already seen that although slightly in the background during the birth and nursing experience, the feeling of security which the father imparts to the mother is passed on through her to their child. Days later, he begins to take the baby up, to play with him and to otherwise assist in caring for him. In fact, he should participate in all of the contacts with the infant as does the mother even though, of necessity, he does so less frequently. This is of the greatest importance since it constitutes the most natural and most secure footing on which their entire future relationship will be built. Both benefit immeasurably from this shared experience.

Invariably fathers who wholeheartedly follow these suggestions are amazed at the pleasures of fatherhood which they may have denied themselves with earlier children. As time goes on, the son whose father enjoys the responsibilities of being husband and father soon comes to share the pleasures of household duties with the father. Son and daughter alike are rendered more secure in life when they share with father and mother the uplifting experience which accompanies church attendance and responsibilities. If the boy sees in the loved and respected parent a man whose ideals and ethical standards are those which he can accept for himself, he will learn by example how to make them a part of himself.

Sometimes it happens that a child feels rejected by a parent when in reality no rejection exists. Consider little Tommy, age 4. Tommy thought a great deal of his father and, as with most boys of his age, he liked to do things with his father. He also liked, as he phrased it, "to help" his father although his notion of helpfulness sometimes seemed a bit exaggerated to the parent.

Tommy's father owned and operated a small radio repair and appliance store some distance from their home. It was his habit from time to time, on Sunday afternoon, to spend an hour or so in the store doing minor jobs which, however, did not demand his undivided attention. On these occasions Tommy usually went along to their mutual enjoyment. Their activities on these particular excursions were not such as to test the limits of the boy's attention span and so very little difficulty arose between them at these times.

There were other occasions, however, when the father had major repair jobs to do which required his undivided attention. When this was to be the case the agreed upon plan was to give Tommy some tools with which to play while Father con-

centrated on his work. The plan worked for just about two minutes. At the end of this period Tommy's attention span was exhausted and the inevitable impulse to "help" Father asserted itself. Within the next few moments Father had developed a very low opinion of Tommy's ability to "help." Not wishing to disillusion the boy in this respect, he resorted, instead, to a simple scolding designed to stop once and for all Tommy's attacks upon the many intriguing items on the work bench. Not so with Tommy. He seemed to have an abiding faith in his ability to "help" his father. After a few more rounds of this, Father gave up the attempt and they returned home.

Following this experience Father, without prior consultation with Tommy, decided that in the future Tommy was not to accompany him whenever he had a major job to do on Sunday. This arbitrary handling of the situation proved to be no solution at all because as the father prepared to leave the house on the next occasion from which Tommy was to be excluded, there were many tears and much begging. Besides, Tommy was confused because on the other occasions, when no special work was planned, he was still allowed to go as previously. He, therefore, could see no basis for these s e e m i n g l y arbitrary discriminations.

On those occasions when he was not permitted to go he insisted, "But Daddy, I WANT to go." It was evident from the emphasis which he placed upon the "I WANT" that Tommy was capable of no other consideration at that moment. Sensing the importance of the "I WANT" factor in his son's emotional reaction, the father echoed this sentiment when he sat down to explain to the boy, that Daddy also WANTED him to go along and that it was not that Tommy was NOT WANTED. He emphasized that he always enjoyed Tommy's company very much and that when it was not possible for them to be together Father was just as disappointed as was Tommy.

He then went on to explain, as best he could, the differences between the two situations and he reviewed with the boy their previous difficulties. Gradually, Tommy's insistence subsided and to his father's complete surprise was replaced by a cheerful acceptance of the refusal. When these situations arise now, there is very little difficulty because the father has learned to take the time to convey to the boy his keen disappointment that circumstances, beyond his control, deprive him of the pleasures of Tommy's company.

Of course, Tommy still understands nothing of what is meant by "circumstances beyond one's control," or "undivided attention." What he does understand, however, is that his father really does like to be with him and that when this cannot be, his father is just as unhappy about it as is Tommy. It was not the so-called "reasoning" here which proved effective. Rather, the "reasoning" served as a sort of vehicle by which the father's sincere feelings were conveyed to the boy. Thus, it was that in their little crisis the father succeeded in making it clear to Tommy that even if they could not share the pleasures of being together, they at least shared the keen disappointment of being separated.

It is also evident from this that what Tommy really wanted, was not to go to his father's store or to work with his father's tools, but simply to be with his father and also to be reassured that his father enjoyed being with him. The basic fact is that it is not the lavish bestowing of gifts, or great material sacrifices or even the knowledge that both parents work hard to provide agreeable surroundings which, to the child, is indicative of parental love. Rather, it is the reassuring physical presence of a parent in a shared experience which, to the child, really means love and security.

FATHER-DAUGHTER RELATIONSHIP

It never occurs to some fathers, until it is too late, that they are as important in the lives of their daughters as they are to their sons. Sometimes they seem almost to boast that they "don't know anything about women," and they include in this broad classification of "women," their own little girls. George, a mechanic, handy with tools and materials but inexperienced with the opposite sex was just such a man. He and his wife had two daughters and a son. George got along splendidly with his young son but seemed to be a virtual stranger to the two daughters.

It seemed to George's wife that he and the boy were forever making repairs and improvements on the house, especially on the outside of the house, or in the basement. These activities, to George, represented the utmost in a man's devotion to his family and it was always a source of bewilderment to him that his wife complained repeatedly of feeling neglected.

The older daughter, Anne, age 9, seemed especially unhappy, lonely, and quarrelsome. George, sensing that something was wrong, decided to do something constructive about the situation. He is now learning to devote himself more directly to the three feminine members in his household. When he comes home from work he makes it a point to seek each one out individually in order to exchange kisses with them. If Anne is working on a doll dress he comments on the excellence of her craftsmanship or how pretty the doll looks. What is more, he enjoys it thoroughly.

During the Christmas holidays he took all three children downtown on a Saturday afternoon to see Santa Claus. They all had the best time they had ever had together. Anne is no longer so quarrelsome and unhappy and she is delighted

with the attentions she now receives from her father.

The father who cultivates his daughter's affections at her level of appreciation helps her lay a foundation of security and self-confidence in her relationships with the opposite sex later in life. For the girl who knows that the father whom she loves and respects, places a high value on her kisses will, herself, place an equally high value on them when she is out with admirers of her own age.

SEX EDUCATION

Both parents exert a vital influence upon the personality development of their children when they are prepared to assist the child in coping with problems of sex as these problems occur at successive age levels. This is not the same as prying curiously into what are essentially private matters. To do this will only drive the material into an even less accessible realm of secrecy. Rather, it calls for a wholehearted acceptance of the young person and his problems, so that he will sense the presence of a helping hand and be more inclined to reach out in order to grasp it.

Well balanced sex education begins in infancy and earliest childhood. This education is facilitated greatly by applying the correct anatomical names to the sexual organs. The physical differences between the sexes can be learned quite simply by casual observations within the family circle providing no special effort is made to guard this information behind closed doors or concealing garments. To do so only adds to the mysteries of sex and arouses an unhealthy curiosity.

The unrepressed child will ask straightforward questions about sex. To these he is entitled straightforward answers which offer neither too much nor too little. If questions are not forthcoming, the alert parent creates situations which will encourage them. By being able to talk freely of sex within the parental family circle, there is less need to experiment with it outside the home, less feeling of guilt and an easier acceptance of it later on in the marital situation.

CONCLUSION

In conclusion, it should be emphasized that material of this nature should be presented to parents in simple terms, that parents should realize that it is the family unit which is the principal instrument for emotional education and that although primarily the preceptors of emotional growth, parents also are students who should emerge from the experience of parenthood with greater emotional maturity. Finally, as the basic unit in a democratic society, the family should be organized along democratic lines; with constructive devisions of authority and responsibility but also with equal opportunities, irrespective of age or sex, for the sharing and exchange of feelings within the group.

Progressive Muscular Dystrophy Report on Treatment

Ten consecutive unselected patients with progressive muscular dystrophy were given amino acids, folic acid and selected vitamins on the assumption that the wasting process in the muscle is secondary either to failure of the digestive system to split the protein molecule into the basic amino acids or to a disorder of the enzymatic system for synthesis of muscle tissue.

The three classical types of muscular dystrophy —Erb's juvenile, fascioscapulohumoral, and pseudohypertrophic—were represented. Some of the patients had had various forms of therapy previously without arrest of progression.

Each patient was given daily:

Vitamin B_{12}	50.0 micrograms
Folic acid	3.34 mg.

and a proprietary protein hydrolysate mixture that in amounts given, contained approximately:

Amino acid produced by enzymatic digest of casein	16.0 gm.
Ascorbic acid	100.0 mg.
Thiamine hydrochloride	10.0 mg.
Riboflavin	6.0 mg.
Pyridoxine hydrochloride	1.0 mg.
Calcium pantothenate	1.0 mg.
Niacinamide	50.0 mg.
Vitamin A	5,000 USP units
Vitamin D	500 USP units
Iron peptonate	0.1 gm.
Tribasic calcium phosphate	1.0 gm.

Within three weeks to one month after the beginning of treatment a subjective sense of well-being increased and strength developed. All the patients were cheerful and gained confidence. Relatives and friends reported them to be less irritable. The improvement continued after the first month and was manifest in the ability to carry out more activity progressively with less fatigue.—J. Ray Van Meter, M.D., San Francisco: *California Med.*, 70:297, October, 1953.

Diet in the Treatment of Hypertension

Work which is now in progress in our laboratory indicates that, under certain conditions, both fat and carbohydrates tend to elevate blood pressure, while protein not only tends to counteract this effect, but also seems to have a lowering effect upon blood pressure.

It is also well known that fat may be very injurious to the cardiovascular system, largely by accelerating the rate of production of endogenous cholesterol. Experimentally it has been possible to produce necrotizing arteritis in dogs with high fat diets. Both fat and carbohydrates tend to cause obesity.

On the basis of these facts, it is my personal opinion that the diet in hypertension should be high in protein, low in fat, and moderate in carbohydrate.—C. M. Wilhelmj, M.D., Omaha: *Nebraska State M.J.*, 39:49, February, 1954.

Some Social Factors in Involutional Psychosis

ROBERT M. FRUMKIN

ABOUT 5 per cent of all first admissions to Ohio state mental hospitals are involutional psychotics—involutional psychosis being one of the most common psychoses among persons of middle age. The median age of first admissions is 55 years. Around 4 per cent of all residents, however, have this mental illness, and the median age of resident mental patients is 63 years. For every man admitted as an involutional psychotic to an Ohio state mental hospital there are usually two or three women admitted with this mental illness.

The Author

● Mr. Frumkin, Columbus, a graduate student at the Ohio State University, is social research analyst in mental hygiene, Bureau of Research and Statistics, Ohio State Department of Public Welfare.

METHOD

In order to ascertain some of the social factors related to involutional psychosis, the first admissions to Ohio state mental hospitals for the year ended June 30, 1952, (and so afflicted with this mental illness) were broken down by sex, environmental background, extent of education, occupational group, race, and marital status. On the basis of data obtained from the 1950 census of Ohio, it was then possible to compute rates of admission for these various factors in relation to involutional psychosis.

FINDINGS

1. **Environment:** The following rates of first admissions with involutional psychosis per 100,000 Ohio general population were found among persons of urban and rural background:

Environment	Total	Male	Female
Urban	3.0	1.8	4.2
Rural	1.9	1.0	2.9

It is evident from the above data that urban inhabitants have rates of involutional psychosis which are twice as high as rates for rural persons.

2. **Occupation:** In the accompanying table 1 rates of involutional psychotic first admissions per 100,000 employed Ohio population are broken down by occupational group according to data obtained from the 1950 census of Ohio.

TABLE 1.—RATES OF INVOLUTIONAL PSYCHOTIC FIRST ADMISSIONS TO OHIO STATE MENTAL HOSPITALS, BY SEX, BY OCCUPATIONAL GROUP, YEAR ENDED JUNE 30, 1952.

Occupational Group	Total	Male	Female
Professional & Semi-Professional	1.5	1.2	2.1
Managerial	1.6	0.9	6.4
Clerical, Sales	1.6	2.3	1.0
Skilled	4.4	3.9	19.6
Semi-Skilled	1.4	1.5	1.2
Unskilled	15.8	13.7	67.5
Service	10.8	8.2	12.7
Agricultural	5.4	5.8	0.0

An examination of table 1 reveals that persons within occupational groups generally indicative of low income, prestige, and socio-economic status have the highest rates of involutional psychosis (e. g., Unskilled and Service Workers), whereas individuals in occupational groups generally indicative of high income, prestige, and socio-economic status have low rates (e. g., Professional and Semi-professional Workers).

3. **Race:** If we compute rates of first admissions by race, per 100,000 general Ohio population we find the following incidence of involutional psychosis:

Race	Total	Male	Female
White	2.9	1.8	4.1
Negro	2.2	0.8	3.5

The above data indicate that Whites have a slightly higher rate of involutional psychosis than do Negroes.

4. **Education:** The extent of an individual's formal education seems to be inversely related to the probability of his becoming an involutional psychotic. Thus, according to the 1950 census data on persons 25 years and older in Ohio, rates by education per 100,000 of that population were as follows:

Education	Total	Male	Female
No Education	10.6	0.0	21.9
Elementary Schl.	7.8	5.0	10.6
High School	2.2	0.8	3.3
College	0.8	0.3	1.4

5. **Marital Status:** There seems also to be an inverse relationship between family organization and rates of involutional psychosis. Thus, rates per 100,000 Ohio population 14 years old and over, by marital status, according to the 1950 census, were as follows:

Marital Status	Total	Male	Female
Single	4.0	1.6	2.6
Married	7.1	2.0	5.1
Divorced or Widowed	13.1	5.2	8.0

If we consider divorce and widowhood as evidence of family disorganization we can see that such an inverse relationship, as suggested previ-

Submitted August 28, 1953.

ously, is of some validity. The disparity in the rates for single and married persons is due chiefly to differences in the ages of these two groups, the latter being older than the former; plus the fact that involutional psychosis is an illness of middle-aged persons, of whom the majority are married.

SUMMARY

In summary, the present study reveals the following facts concerning involutional psychotics admitted to Ohio state mental hospitals:

1. He is likely to be of middle age.
2. His formal education is generally terminated by the eighth grade.
3. His occupation is most generally indicative of low income, prestige, and socio-economic status. Thus, for example, high rates are found among unskilled and service workers.
4. He is more frequently White rather than Negro.
5. He is more often an urban rather than a rural inhabitant.
6. His marital status is likely to be indicative of family disorganization as manifested in divorce or widowhood.
7. He is two to three times less likely to be a male rather than a female, i. e., females have much higher rates than males.

Management of Essential Hypertension

The probelm which one must decide first in the management of essential hypertension is which patients not to treat. Here, especially, one must guard against overtreatment with dietary restriction, limitation of physical activity, creation of anxiety and use of drugs. There is naturally a great difference of opinion on this. It varies from those who feel that nearly all patients should have rather intensive treatment to a good friend of mine, who is a surgeon, and tells me that when he finds a patient in his office with high blood pressure, he states to him that if he himself had it he would go home and forget it and "that is what I advise you to do."

Meilman believes that it is easier to select patients who should not be treated with drugs now available. He states that elderly patients with hypertension of 15 or more years duration with no evidence of hypertensive disease except moderate enlargement of the left ventricle need no dietary restrictions or drugs. Patients, especially those over 60, with high systolic pressures but diastolic levels of 100 or less usually need no drugs. For persons in their twenties with no signs or symptoms other than moderately elevated blood pressure he advises only supportive psychotherapy.—Wilfrid C. Gettelfinger, M.D., Louisville: *J. Kentucky State M.A.*, 51:434, October, 1953.

Method of Control of Trichinosis Through Federal Meat Inspection

The method of control of trichinosis currently employed by the Federal Meat Inspection Service contemplates special treatment under inspection supervision for all pork products customarily eaten without cooking. The so-called microscopic examination was used between the years 1890 and 1906 but only on export pork. Since then no microscopic examinations have been made of any pork coming under the Federal meat inspection program.

Under the current program almost all processed pork products are classed as pork products customarily eaten without cooking and required to be treated under inspection supervision to destroy possible live trichinae. The exceptions include bacon, fresh pork sausage, and similar breakfast sausage, and hams and pork shoulder cuts that have been cured but not smoked or otherwise processed. Also included are such fresh pork cuts as pork chops and pork roasts.

Thoroughly tested heating, refrigerating, or curing processes are prescribed and used in Federally inspected meat packing plants under close inspectional supervision for the treatment of all pork products customarily eaten without cooking. An extensive survey made recently found without exception that these products were safe as evidenced by the finding of only dead trichinae and these only in a comparatively small number of cases.—A. R. MILLER, Federal Meat Inspection Service, U. S. Department of Agriculture, Washington, D. C.

Abstract of paper presented at 1952 National Conference on Trichinosis, Auditorium, American Medical Association, December 15, 1952.

Effect of Banthine® and Similar Agents on the Urinary Tract

Anticholinergic drugs such as banthine® are useful in some conditions. Most observers agree that they are of little value in urinary frequency of functional origin.

In organic disease they can be very useful in relieving the symptoms of chronic cystitis, interstitial cystitis, and uninhibited neurogenic bladder, and it has been proved that they can increase the capacity of certain patients with contracted bladder. We have had success in the relief of mild postcystoscopic and postoperative spasm with banthine® and related drugs. A few observers have reported good results in the treatment of enuresis in some children, but in adults results have been disappointing. — John W. Draper, M. D., and Adrian W. Zorgniotti, M. D., New York City: *New York State J.M.*, 54:77, January, 1954.

Non-Articular Rheumatism

R. H. JACQUES, M. D.

DIFFERENTIAL diagnosis between non-articular rheumatism and arthritis is often difficult. The confusion of these conditions is not surprising for each has symptoms of pain, tenderness, and stiffness in or about the joints, and each presents jelling as an outstanding phenomenon. However, in non-articular rheumatism, the joints are normal and the symptoms arise from the motivating strictures such as muscles and tendons.

Forms of non-articular rheumatism include lumbago, bursitis, tendonitis, tenosynovitis, fibrositis and periarthritis. These conditions may be either primary—without demonstrable cause or sign of systemic disease; or secondary—a manifestation of disease such as infection; or associated with various forms of arthritis such as rheumatoid, rheumatic fever, gout, etc.; or the results of strain or trauma, exposure, occupation, or postural and structural abnormalities.

It is often impossible to differentiate early, insidious, rheumatoid arthritis from non-articular rheumatism, and the diagnosis is made only when the clinical syndrome progresses sufficiently to give objective evidence of rheumatoid joint changes.

PRIMARY FIBROSITIS

Primary fibrositis may be either local or generalized. The disseminated form involves muscle sheaths, tendons, fascia, and aponeuroses. It is usually chronic, affects any age group, and is characterized primarily by jelling or the aggravation of pain and stiffness after prolonged rest. At times tenderness exists in sharply localized areas from which pain radiates through the distribution of the tissue structure. These regions are called "trigger zones." Cold, dampness, and rain usually aggravate symptoms, while warmth and dryness bring relief. The disease is usually not incapacitating but has a distinct nuisance value.

Localized fibrositis frequently occurs in the posterior neck muscles, the lumbar paravertebral muscles, the pronators of the forearm, or in the shoulder girdle; and arises from irritation of muscle sheaths, fascia, tendons and ligaments. The constant objective finding is muscle spasm and symptoms are produced by prolonged hypertonic action of a muscle with subsequent aching and tenderness and trigger points.

The more acute the onset, the more rapid the resolution of these disorders. States of chronic emotional restraint are often major factors in perpetuating muscle hypertonicity. The "tendon attachment syndrome" as typified by radio-humeral bursitis or "tennis elbow" is a form of fibrositis without grossly evident inflammation.

Submitted July 2, 1953.

The Author

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The cause of primary fibrositis is unknown. Some rheumatologists object to the concept of fibrositis because of the lack of characteristic microscopic pathologic changes, but it represents a distinct clinical syndrome. Infection, trauma, unusual physical activity, exposure to dampness and cold all seem to be aggravating factors. It may well be that this condition represents, in miniature, a collagen disorder similar to rheumatoid arthritis. In primary fibrositis there is a complete lack of abnormal laboratory or x-ray findings.

The treatment is purely symptomatic. Mild exercises after heat application is useful, but strenuous exertion, should be avoided. Heat is best applied in the form of hot, moist packs and should be followed by light, sedative massage. Salicylates are usually helpful. When trigger points are present, local injections of 1 per cent procaine at five to seven day intervals may bring relief by breaking the reflex responsible for referred pain.

Exposure to dampness and cold should be avoided. Gold salts are not helpful. The value of cortisone or ACTH in fibrositis has yet to be evaluated. No satisfactory antispasmodic drug affecting skeletal muscle tone has been produced. The effects of mephenesin are variable and usually inadequate.

BURSITIS

Bursitis is a form of non-articular rheumatism which occurs primarily in the subacromial, olecranon, ischial, prepatellar and achilles bursae. The cause is often found to be unusual activity, particularly when accompanied by exposure to dampness and cold. Focal infection apparently is not a factor.

Subacromial bursitis is often a secondary reaction to calcareous tendonitis in the musculotendenous cuff of the external rotators of the shoulder. The calcareous deposit ruptures into the bursa, setting up an acute mechanical irrita-

tion. The bursa becomes distended with fluid containing calcium in a suspension, causing pain and tenderness well localized to the area of the bursa. Abduction and rotary movements of the humerus are painful. Roentgenograms are negative except for the presence of soft tissue calcium deposits.

Rest of the shoulder is advisable in the acute stages. Butazolidin® in doses of 400 mgm. per day is usually the most effective analgesic. When possible, the bursa should be aspirated and then infiltrated with procaine or hydrocortisone and followed with roentgen therapy.

Calcium deposits which continue to produce symptoms six weeks after adequate roentgen therapy, should be excised. In the hyperacute form, where nothing can be done except under general anesthesia, it is probably best to excise the calcareous deposit at once.

Adequate physiotherapy must be given to allow early active motion and prevent periarticular adhesions. Accumulations of fluid in superficial bursae, such as the olecranon bursa, should be aspirated and replaced with 0.25 to 0.5 cc. of hydrocortisone. It may be necessary to repeat this process several times before a cure is effected.

PERIARTHRITIS

The shoulder-hand syndrome, the incomplete form of which is known as periarthritis of the shoulder, may follow myocardial infarction, cerebral vascular accidents, painful intrathoracic lesions, or the Parkinsonian syndrome. In most cases, no definite causative factor can be elicited. The shoulder or hand or both are painful either unilaterally or bilaterally. Paresthesias in the arm and hand usually occur. When the shoulder is involved, motion becomes painful in all directions, but principally in abduction and external rotation. The affected hand becomes slightly edematous. After several weeks, the swelling subsides and muscular atrophy occurs in the hand and about the shoulder. The elbow is usually not involved.

In the early stages, roentgenograms are normal. Later osteoporosis develops but the joint structures remain normal. Dupuytren's contractures of the palmar fascia are a common residue.

Treatment with the usual physical measures, plus analgesics and cortisone is successful if initiated before severe trophic changes have occured and if the patient will cooperate in an active exercise program. Procaine blocks of the cervical sympathetic chain are very variable in their effect and even when helpful, the duration of benefit is usually brief.

Rehabilitation largely depends on the institution of active motion with persistent physical and occupational therapy. Recent studies indicate that the onset and course of these shoulder symptoms may be intimately related to emotional reactions and stressful life situations.

TENOSYNOVITIS

Specific infections, such as tuberculosis or pyogenic bacteria may cause inflammation of tendon sheaths. Minor trauma is often a precipitating factor. Treatment with antibiotics and immobilization is usually highly successful. When constricting tenosynovitis with a "trigger finger" is present, incision of the tendon sheaths is required.

PSYCHOGENIC RHEUMATISM

A common form of rheumatic disorder is "psychogenic rheumatism." Psychoneurotic persons in emotional conflict caused by psychic trauma, fear, or apprehension may experience arthralgia, muscle and tendon pain, stiffness and interference with joint motion resembling common forms of arthritis or fibrositis.

Bizarre deformities, overemphasis of symptoms and recognition of other evidence of psychoneurosis are helpful diagnostic signs. Every effort must be made to recognize these cases as early as possible, and to insist upon proper psychiatric care. Medical and physical therapy tends to convince these patients that they are suffering from organic disease, and frequently entrenches the situation beyond relief.

SUMMARY

Various common types of non-articular rheumatism have been discussed and suggestions regarding therapy have been made. Fundamental knowledge regarding etiological mechanisms is lacking in most cases. Minor trauma and emotional tension seem to be causative factors in some cases.

CONCLUSION

Non-articular rheumatism and arthritis must be differentiated primarily because of prognostic and therapeutic differences.

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Operability of Carcinoma Of the Lung

Unless the patient's general condition precludes an operation, every suspected or known case of lung cancer should have the benefit of surgical intervention. The only exceptions to this rule are those patients in whom absolute evidence of inoperability is established.—Brian B. Blades, M.D., Washington, D. C.: *Pennsylvania M.J.*, 57:25, January, 1954.

Prevention of Reactions in Intravenous Urography (Preliminary Report)

S. WILLIAM SIMON, M. D., HENRY I. BERMAN, M. D., and FRED C. BARALD, M. D.

THE method originated by Getzoff to reduce the incidence of reactions from the intravenous injection of diodrast® (the diethanolamine salt of 3,5-diiodo-4-pyridone-N-acetic acid), neo-iopax® (the disodium salt of N-methyl-3, 5-diiodo-chelidamic acid) and urokon® sodium (the sodium salt of 3 acetylamino-2, 4, 6-triodobenzoic acid) by giving pyribenzamine® (N, N-dimethyl-N'benzyl-N' [Alpha-pyridyl] -ethylene diamine) 50-200 mg. orally one hour previous to injection, is well known.[3] Dosage was regulated by the size of the patient, history of allergy and results of drug sensitivity tests. General reactions occurred in 10 of 211 patients or 4.74 per cent and two of these reactions are described as "severe."

We undertook the present study, which is continuing, in order to simplify and standardize the procedure and, if possible, to reduce the rate of reaction even more.

For several years we have been performing sensitivity tests both on the conjunctiva and the skin. Histories have been carefully taken and those with past or present allergies watched most closely. In spite of this and contrary to the findings of Alyea and Hayes,[1] we have been unable to predict sensitivity reactions on this basis prior to intravenous injection. In our opinion, a fool proof, standard method is needed for all patients whether allergic or not and regardless of sensitivity tests.

METHOD

In each case 2.5 ml. of chlor-trimeton®* (1-parachlorophenyl-1-[2-pyridyl]-3-dimethylaminopropane) maleate solution, which contained 5 mg. of the drug, were mixed in the syringe with the contrast medium to be injected. One ml. of this mixture was given intravenously as a test dose and with the needle in the vein a pause of approximately one minute ensued to determine individual tolerance. If no adverse reactions occurred, the remainder of the solution was injected quite rapidly.

RESULTS

One hundred forty-six (146) patients were given the dye and chlor-trimeton.® Ten received urokon,® 46 diodrast,®, and 90 neo-iopax.® All reactions noted below were mild and occasioned no alarm in either the patient or physician. In no case was additional medication necessary.

The Authors

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- Dr. Barald, Dayton, is chief, x-ray service, Brown General Hospital, V. A. C.

CHART I

	Urokon (70%)	Diodrast	Neo-Iopax
Percentage of patients exhibiting one or more reactions	10	24	7.7
Percentage of patients with:			
Nausea	0	8	1.1
Vomiting	0	0	0
Arm pain	10	4	3.3
Foreign taste	0	6	4.4
Mild urticaria	0	2	0
Severe urticaria	0	0	0
Flush	10	15	2.2
Dizziness	0	0	0
Sneezing	0	0	0

Chart 1 compares very favorably with the series of Nesbit and Lapides.[4] Eliminating flushing and foreign taste, which are definitely not allergic reactions, our percentages are far below theirs. Even including these, the overall percentage of reactions compare as follows: with urokon® 10 to 19, with diodrast® 24 to 62 and with neo-iopax® 7.7 to 36. Flushing and foreign taste accounted for 75 per cent of our reactions and about 20 per cent of theirs. Both symptoms lasted less than one minute.

One of our patients who exhibited a mild urticaria consisting of a few small wheals which disappeared within 15 minutes had had on a previous pyelogram made with the same dye (diodrast®) giant hives and syncope.

Allergic histories were obtained in nine patients given diodrast® but their reaction rates and severity were no different from the other 37 patients.

If flush, foreign taste, and arm pain are elimi-

Submitted June 26, 1953.

*Chlor-Trimeton used in this series was furnished through the courtesy of Schering Corporation, Bloomfield, New Jersey.

nated from the series as done by Barry and Rose,[2] we find only six mild reactions in 146 patients or a little over 4 per cent compared to their 10.5 per cent.

CASE REPORT

The following case report is probably more convincing than any figures or percentages:

A paraplegic physician gave a history of a severe reaction to intravenous urography in the past, manifested by dizziness and blacking-out followed by severe vomiting. A conjunctival test previous to injection had been negative. He did not know what medium had been used. On October 7, 1952, following a negative eye test to diodrast,® and no reaction to 1 ml. of diodrast® chlor-trimeton® mixture given intravenously, 20 ml. of the mixture was administered by the usual intravenous route. The patient experienced transient mild arm pain and a slight face flush lasting less than 30 seconds. No other reactions were noted.

On January 7, 1953, during a performance of parasympathetic block, some diodrast® was injected intramuscularly to ascertain the position of the needle by x-ray. Immediately after the injection of less than three ml. of dye, the patient had a severe reaction manifested by nausea, vomiting and mental confusion necessitating discontinuance of the entire procedure.

SUMMARY

This preliminary report has demonstrated the possibility of radically reducing reactions due to the dye used in intravenous urography by the simultaneous injection of an antihistamine drug (chlor-trimeton®). Only mild reactions resulted and if flush, arm pain, and foreign taste are not considered, the overall rate was about 4 per cent.

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Colonic Irritability

It is important to realize that most patients with the irritable colon syndrome have a combination of both motor and secretory dysfunction and oversecretion of mucous rarely occurs without some accompanying motor dysfunction. The fundamental factor in the symptom complex, then, is an imbalance between the nervous and the muscular apparatus of the colon, which results in a disturbance in its mechanical and to a lesser degree in its secretory functions.

This imbalance is manifested in the consciousness of the patient by various symptoms, the chief among which are abdominal discomfort or pain, gaseous distention and distress, and an abnormal elimination of fecal material.—Edward J. Donovan, M.D., Denver: *Rocky Mountain M.J.*, 50:952, December, 1953.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Bachelor—Several stories exist behind the origin of this word. The most common one is that the term stems from the Latin words "vacca or bacca" meaning a cow. The Mid-Latin word "baccalarius" at first meant a cow-herd and later any young lad over sixteen years of age. The term was then extended to mean an unmarried man of any age. Academically the term came to be used to designate a young man who had taken his first degree in a college or university. It is said, however, that academically a "baccalaureus" was a scholar who was honored by being awarded the "bacca laurens" or the laurel berry.

Eonism—This is a psychiatric term designating the adoption of feminine habits, manners and costume by a male. The term is derived from the name of the Chevalier de Eon, an 18th Century French diplomat.

Memory—This word is derived from the Latin word "memor" meaning mindful. This in turn may be derived from the Greek word "mnemon" or memory. In Greek mythology the mother of the muses was Mnemosyne, the Goddess of Memory.

Cadaver—Denoting a corpse or a dead body, this Latin term is derived from the Latin word "cadere" meaning to fall. Hence the term literally means the fallen and originally referred to those who "fell" dead in battle.

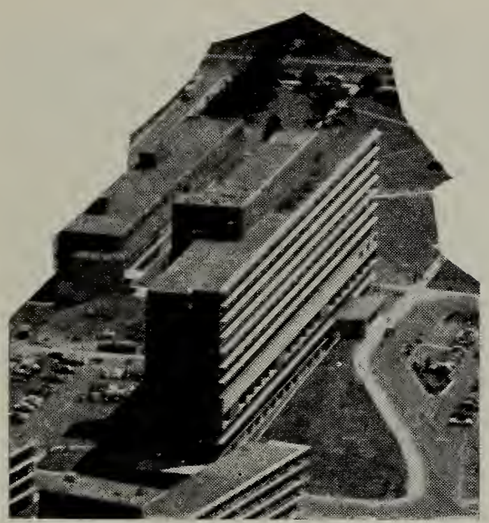
Bulimia—This term for an excessive and morbid hunger is descriptive and signifies an ox-like or increased hunger. It is derived from the Greek word "bous," or ox, which is frequently used as a prefix to augment the meaning of words; plus the Greek word "limos," or hunger.

Ergot—Because this fungus which attacks rye produces a black purplish curved granule resembling in appearance a cock's spur it was named "ergot" from the Old French word "argot" meaning a cock's spur. It is said to have been first used in obstetrics to produce uterine contractions by Paulitzky in 1787.

Cure—Meaning the act of healing, this word curiously enough comes from the Latin word "cura," or pains. Thus a "curate" is one to whom is entrusted the care of painful or distressed souls and to "cure" is to take care of, or to heal, the pains of body or mind.

Fetus—This Latin word which now designates the unborn child was formerly spelled foetus and originally meant offspring or progeny. The term comes from the Latin word "feo," meaning I bring forth, and was introduced in about the 7th Century. It was used by Isidorus and Paul of Aegina at about this time.

—Harry Wain, M. D., Mansfield, Ohio.



A Case Record

From The University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Edward Goodsitt, M. D., President

Presented by Edwin H. Ellison, M. D., and E. von Haam, M. D. Edited by: E. von Haam

PRESENTATION OF CASE

THE patient, a 69 year old white female, was first admitted to University Hospital with complaints of choking, dysphagia, and a persistent productive cough. She had a nodular goiter the size of a baseball which had been present for 15 years. The obstructive symptoms had become more marked in the last six months, while the cough had been present for the past three years. She had suffered an 80 pound weight loss in the past 18 months. Her local physician gave her digitalis and Lugol therapy with some relief.

The results of laboratory examinations at the time of the first admission were essentially normal except for a basal metabolic rate of plus 36. Because she had previously received iodine, the radioactive iodine uptake studies were inconclusive and the patient was sent home on a regimen of a daily dose of 30 mg. of propylthiouracil with penicillin and streptomycin after a hospital stay of one week. It was planned to readmit the patient in one month for re-evaluation and definitive therapy.

After her discharge the patient felt fairly well for two days but then began to have difficulty in swallowing and became delirious. Her condition deteriorated and one week after leaving University Hospital she became stuporous and was admitted to another hospital for oxygen therapy. She was transferred to the University Hospital 48 hours later because of delirium, inability to eat, profuse sweating, rapid pulse and a productive cough.

The patient had been treated for heart trouble for many years and had been on a maintenance dose of digitalis.

Physical Examination: At the time of the second admission the patient was severely ill, poorly oriented, had a temperature of 103°F., a pulse of 160, respirations of 28 and a blood pressure of 160/75. She had an ineffective cough reflex. The mouth was dry. The trachea was deviated to the right due to pressure by a large nodular goiter roughly the size of a baseball. There was no bruit. The anteroposterior diameter of the chest was increased. The lungs were clear to percussion and auscultation. The heart revealed no enlargement by percussion. There was a marked tachycardia with apical thrust and a soft blowing systolic mitral murmur. The abdomen was normal. The extremities showed no edema.

Laboratory Data: On the second admission the red blood cell count was 5.04 million with 15.7 Gm. of hemoglobin; the white blood cells numbered 14,350 with 91 per cent neutrophils and 9 per cent lymphocytes. The urinalysis revealed 4 plus sugar, 1 to 2 white blood cells and 6 to 8 red blood cells per high power field. The serology was negative for syphilis. The spinal fluid was normal. The blood cholesterol was 122.5 mg., cholesterol esters 65 per cent. The blood chlorides were 83 meq., the serum potassium was 5.5 meq., the serum sodium 125 meq. The CO_2 combining power was 81.5 vol. The blood urea nitrogen and the blood calcium were within normal limits, the prothrombin time was 46 per cent. The total blood volume was determined at 4245 cc. An electrocardiographic tracing was suspicious of a myocardial infarct.

X-Ray Studies: X-ray examination of the chest showed a large thyroid shadow which extended substernally toward the arch of the aorta. The trachea and esophagus appeared markedly compressed. The lungs showed increased vascular markings as seen in cases of chronic passive congestion. On her second admission the heart and the hilar vessels appeared considerably more distended.

Hospital Course: The patient was perspiring profusely and remained lethargic. Two days later her tongue was noted to be deviated to the left and she developed 2 plus presacral edema

and dependent lividity. She received digitoxin, wycillin,® gantrisin,® aminophylline, Lugol's solution intravenously, and parenteral fluids. However, she expired three days after her second admission with progressive hyperpyrexia, tachycardia and rapid respirations.

CLINICAL DISCUSSION

DR. E. H. ELLISON: I happened to see this patient while she was in the hospital and she presented quite a clinical problem. There are a few facts I would like to point out to demonstrate some of the difficulties with which we were confronted. I saw her for the first time about the second day of her first hospital admission and was impressed by the marked air hunger which forced the patient to sit up in bed at all times. She also had marked trouble in swallowing. Her large goiter seemed to almost obstruct her airway and in addition she had an almost persistent productive cough and expectorated a foul-smelling purulent exudate.

The clinical diagnosis at her first admission was that of a toxic nodular goiter complicated by some type of bronchitis or chronic lung infection. Whether or not she suffered from bronchiectasis could not be determined. She had been on iodine before she came to this hospital and for this reason iodine uptake studies were of little value for the diagnosis of thyrotoxicosis, and that was a diagnosis that had to be made or excluded if one were to outline a good plan of therapy for this extremely ill patient.

Her fast pulse could be explained by many other factors. The history shows she was a chronic cardiac patient and that she had been receiving digitalis for a number of years from her family physician. At the time of admission her pulse rate was extremely high even in the face of digitalis therapy. Together with x-ray studies and her general evaluation, we felt that she was at least not in decompensation at the time of her admission although she certainly presented a borderline cardiac case.

The 80 pound weight loss in the history of the patient is questionable. Actual figures taken from the nurses' notes in the chart make a 30 pound weight loss more plausible than the 80 pound weight loss. Almost any chronic illness, not only thyrotoxicosis, can be responsible for this. We felt, however, that the weight loss was caused by thyrotoxicosis because of her large nodular goiter. A patient who develops toxicity in a colloid nodular goiter has good reasons to start losing weight.

Another symptom that pointed towards thyrotoxicosis was her chief complaint of severe exhaustion. She was so tired that she had been bedfast since the previous summer and was only up and about with the aid of either a member of her family or some good-hearted soul who happened to be there. Such complete exhaustion appears to me rather typical for thyrotoxicosis manifesting itself late in life. Sometimes this represents the only symptom that we find.

BASAL METABOLISM

Her basal metabolism was increased to plus 36. I do not think this helps much in the differential diagnosis. Certainly such a patient could not submit to a basal metabolism test without becoming dyspneic and excited. She certainly suffered from severe tracheal compression. Whether or not she had a chronic infection of the trachea, the bronchi or the bronchioles remains uncertain. No sputum studies were done on this patient, which I certainly consider a clinical oversight because in order to manage this patient most effectively we certainly should know what sort of organisms we were dealing with. She received the usual wycillin®-streptomycin combination with the purpose of providing her with a wide range antibiotic drug which would control her mixed infection.

She was sent home on routine preoperative preparation. I don't think we planned to operate on this patient unless she made marked improvement or the tracheal obstruction itself became so severe that it was actually going to make her lose her life. We had every reason to believe that this was an extremely poor risk patient. The incidence of thyrotoxicosis in this age group, the loss of weight and the background of cardiac disease, all put her definitely in the poor risk group. So I think we had ample reason to feel that she would be best off with medical therapy unless circumstances made surgery mandatory.

This patient was discharged with the idea of bringing her back at some later date in order to evaluate the therapy that she had been placed on, and to confirm the clinical diagnosis. Just before her discharge it was decided to treat her with the magic propylthiouracil. Iodine was discontinued. Two days later she was almost in extremis. This occasionally happens with iodine withdrawal, and I believe it would have been better to have had her maintained on iodine together with her propylthiouracil until this drug had had sufficient time to become effective.

SECOND ADMISSION

At the time of her second admission she was returned to us with a diagnosis of thyroid crisis and I think that this probably was likewise the diagnosis of the hospital doctors who saw this patient. I am still not quite clear myself what is meant by "thyroid crisis." I have seen the diagnosis made while there was ample reason to explain all symptoms of a patient on the basis of simple hyperthyroidism and I am not too prone to place her in the thyroid crisis group. Since her pulse was around 160 in spite of digitalis therapy, an electrocardiogram was taken, which gave tracings suspicious of a cardiac infarct. I think she might have suffered an infarct during

the time she was taken off iodine. This occasionally happens.

We are now confronted with a patient with hyperthyroidism and threatening cardiac failure. I also believe that a considerable factor in the course of her second admission was a severe upper respiratory infection caused by aspiration of thick mucus from the trachea. She certainly was markedly dehydrated and according to the laboratory work was extremely low on sodium and chlorides. Her CO_2 combining power of 81 also demonstrated that she was in alkalosis. The latter was probably due to CO_2 retention on the basis of her tracheal obstruction.

I notice that a spinal tap was done at this second admission in order to rule out a cerebrovascular accident as a cause for her rapid decline. The finding of sugar in the urine has little significance in view of the normal blood sugar and probably is caused by some previous administration of glucose. A low prothrombin level is frequently observed in thyrotoxicosis particularly in a remission. It is explained on the basis of a liver function injury and caused the administration of vitamin K.

TREATMENT

The patient was treated during her second admission with digitoxin, wycillin® and aminophylline. The only possible explanation for the latter drug was that some observers considered her dyspnea of the asthmatic type. I wonder whether a tracheotomy would not have been better for this patient, who obviously was suffering from progressive obstruction of her respiratory pathway. It is my hunch that such a step was considered but not executed because of the difficulties presented by the large goiter. Terminally the patient showed progressive hyperpyrexia, tachycardia and tachypnea and expired on her fourth hospital day of her second admission.

In summary, therefore, we are dealing with a patient suffering from thyrotoxicosis on the basis of hyperplastic changes in a large colloid nodular goiter. It was felt that she should be treated as a medical case on the basis of a poor surgical risk, the presence of cardiac disease, her age, and the fact that the goiter extended substernally. The treatment of choice was propylthiouracil which was to be followed by radioactive iodine.

CLINICAL DIAGNOSIS

1. Thyrotoxicosis.
2. Chronic cardiac disease with possible recent infarction.
3. Upper respiratory tract infection with possible terminal bronchopneumonia.

GENERAL CLINICAL DISCUSSION

DR. J. L. MORTON: On the basis of fluoroscopy we considered the goiter to be somewhat toxic. The cardiac pulsations are different in thyrotoxicosis from those of hypertension or from other heart conditions. They are full, vigorous and quicker. The patient also did not have the heart shape of a hypertensive.

DR. ELLISON: You are giving us some added support that this is thyrotoxicosis. Can you help us to explain the purulent cough on this finding?

DR. MORTON: Well, the patient suffered from chronic pulmonary congestion. Whether there is some bronchiectasis present is difficult to say. I think that the tracheal compression alone would make her cough a lot. You can tell better from the sputum whether or not she had bronchitis, bronchopneumonia or bronchiectasis.

MEDICAL STUDENT: Am I correct, Dr. Ellison, in assuming that you do not base your diagnosis of thyrotoxicosis on the elevated basal metabolic rate?

DR. ELLISON: You are correct. The basal metabolism in this case is not worth consideration. In the first place, the patient has a marked respiratory infection. In the second place, I do not think she could even keep a mask on long enough to get a good tracing.

DR. G. J. HAMWI: You base your diagnosis then on the clinical symptoms alone?

DR. ELLISON: The weight loss, the hypertension, the elevated pulse and the marked fatigue.

DR. E. VON HAAM: What is your explanation for the marked hyperpyrexia before death?

DR. ELLISON: Her high temperature occurred only during her last hours and I believe it was probably due to her pulmonary infection rather than a symptom of thyroid crisis.

PATHOLOGICAL DIAGNOSIS

1. Arteriosclerotic heart disease with recent myocardial infarction.
2. Severe tracheobronchitis with patchy pulmonary atelectasis.
3. Nodular colloid goiter with clinical thyrotoxicosis.
4. Leiomyoma of the stomach.
5. Diverticulosis of the colon.

PATHOLOGIC DISCUSSION

DR. E. VON HAAM: The body was that of a well developed white female who weighed approximately 120 pounds. Her neck showed a large nodular goiter. The lower extremities showed pitting edema. The serous cavities appeared normal. The heart was enlarged and weighed 310 grams. The apex of the left ventricle showed a yellowish gray infarct which extended over an area 5 by 2 cm. and involved also the lower portion of the interventricular septum. The coronary arteries showed many bright yellow atheromatous plaques which greatly narrowed the lumens of the vessels. No complete

obstruction could be demonstrated, however. The lungs showed patchy areas of atelectasis without consolidation. The bronchi were filled with thick white tenacious material. The sigmoid contained approximately five to eight small diverticula filled with feces.

The thyroid gland weighed 340 grams (30 grams more than the heart) and surrounded and compressed the trachea. The gland appeared to be firm, pale pink and decidedly nodular. The cut surface also was pale, translucent and nodular. The brain weighed 1180 grams and appeared grossly normal.

HISTOLOGIC STUDY

The microscopic examination of the tissue sections showed a rather recent and extensive myocardial infarction which appeared to be approximately two weeks old. The necrosis of the muscle fibers was rather extensive and there was already invasion of the necrotic tissue by leukocytes. In addition the heart showed hypertrophy and interstitial fibrosis. A recent thrombosis could be demonstrated in a large coronary vessel.

The lungs showed many of the bronchi distended with mucus and changes suggestive of bronchial asthma (thyroid asthma). The liver showed parenchymatous degeneration of moderate degree and did not show any of the more severe changes described in severe hyperthyroidism.

Sections through the thyroid showed a typical colloid nodular goiter with large follicles lined by flat epithelium and filled with rich colloid. However, occasional areas could be observed consisting of small follicles lined by cuboidal cells and containing little or no colloid. In such follicles the colloid was pale and vacuolated. Sections through the brain showed recent vascular thrombosis with incipient encephalomalacia.

In summary, we may then state that the patient suffered from arteriosclerotic heart disease with myocardial infarction. Second, I think that the patient suffered from a large colloid goiter which compressed the trachea and produced chronic anoxia which aggravated her heart condition. Third, I think the patient suffered from a superimposed thyrotoxicosis which, however, was not too severe and far removed from a thyroid crisis. Her final hyperpyrexia can be readily explained on the basis of cardiac failure with cerebral anoxia.

GENERAL DISCUSSION

DR. ELLISON: Two days after she went home something happened to her. She went downhill for four days, was readmitted to another hospital for three days, then transferred here and died four days later. The cardiac infarction may have occurred in that two-day interval at home.

DR. VON HAAM: Well, I think the infarct was probably present when she left the hospital and the fact that she was probably encouraged to move around did not do her any good. She probably was encouraged to do that, wasn't she?

DR. ELLISON: She was for the first time in many months.

DR. VON HAAM: She was encouraged to move around at the most inopportune time.

MEDICAL STUDENT: On what pathological basis could you make the diagnosis of thyroid crisis?

DR. VON HAAM: Pathologically the best support for the diagnosis of thyroid crisis is severe liver damage with liver cell necrosis. I would be reluctant to accept a case as thyroid crisis without finding this liver damage at autopsy. I also would like to see myocardial degeneration such as encountered in diphtheritic myocarditis but no infarction.

DR. ELLISON: The few cases that I have seen that were called thyroid crisis always turned out to be patients like this who had ample other conditions to explain all their symptoms. I feel, however, that there is such a thing as thyroid crisis, certainly good men have seen it.

DR. HAMWI: Do you feel that her symptoms could be explained on the basis that the iodine was taken away suddenly?

DR. ELLISON: Certainly. She became markedly worse when she was taken off. Generally propylthiouracil does not manage a thyrotoxicosis secondary to colloid nodular goiter too satisfactorily and is only recommended for patients in need of immediate benefit.

MEDICAL STUDENT: How would you have used radioactive iodine in this case?

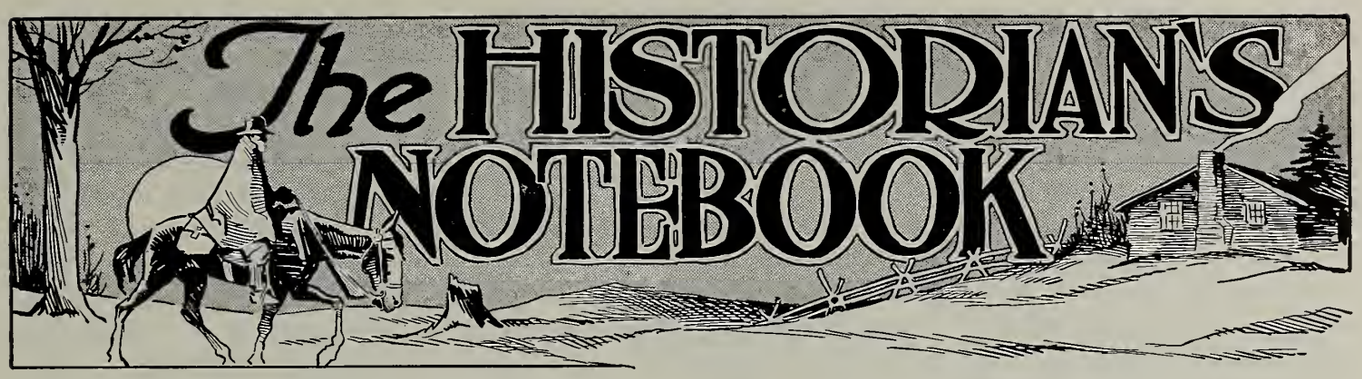
DR. ELISON: I feel that these elderly patients are best managed by giving small doses of radioactive iodine, anywhere from 7 to 10 millicuries, at monthly intervals and watching for the response. There is no way of predicting just how much the gland will take up and so one has to follow up each very carefully clinically at monthly intervals, and one should remember of course that one does not get the maximum response for about four months. In the meantime patients may be carried on propylthiouracil, and I would like to have also added iodine to this patient when she went home.

DR. VON HAAM: Any more questions? This case certainly looked clinically like a thyroid crisis. I think pathologically the case was not a thyroid crisis. It was a case of severe cardiovascular disease in a patient with colloid goiter who also showed moderately severe hyperthyroidism.

REFERENCES

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2. Sloan, E. P.: The Thyroid. Springfield, Ill., Charles C. Thomas, 1932.



Dr. George M. Austin a Super Intellect In Science as Well as Medicine

KELLEY HALE, M.D.

DR. GEORGE M. AUSTIN of Wilmington, Ohio, native of Clinton County, born August 23, 1856, died October 25, 1930, was one of the last of that group of medical men who did so much in various fields of science in the days preceding the advent of the professional scientist.

Dr. Austin had the most remarkable mind I have ever known due to his daily classification of all his new knowledge and experience; and he was always able to call up this knowledge in every detail because of his photographic memory. He was an omnivorous reader of the best in science, medicine and literature. Space will not permit me to record my experience with long years of close and personal association with Dr. George Austin.

AN ENDURING INSPIRATION

Through the years he kept alive in me my natural love of pure science which led to my discovery of twinning in the mollusca, the time of ovulation discovered eight years before Ogino published his first paper, the individual courses of foraging hornets published in the *Journal of The Ohio Academy of Science*, and several other firsts.

A very complimentary letter from the late Dean E. P. Lyon, Medical Department of the University of Minnesota, two years before his death, I credit to Dr. Austin's influence. Dr. Lyon stated, "Of all the thousands of students of mine who have gone into the practical field of medicine, you (Dr. Hale) are the only one that has kept up an active interest in the fundamental sciences." This conclusion was arrived at by his reading reprints of my published papers.

Dr. Austin had a host of friends among the great in science. A bronze plaque was erected to him and placed in front of the Carnegie Library, Wilmington, Ohio, with an outstanding dedicatory ceremony.

It is with great pleasure, therefore, that I present the following appreciation of this man by an outstanding paleontologist of these times, Ray S. Bassler, Ph.D., head curator of geology, United States National Museum, Washington, D. C.:

Some Personal Experiences with Dr. George M. Austin

by

R. S. Bassler, Ph.D.

As a youngster growing up at Cincinnati in the late nineties and spending the summer vacations with my grandparents in Lebanon, I started collecting fossils because of their occurrence in our swimming hole in the old Reservoir Creek. Soon I made the acquaintance of two veteran collectors at Lebanon, Dr. Scoville and Dr. Dyche, who helped me identify finds and from whom I learned that Dr. George M. Austin, student of geology of Clinton County, lived at Wilmington.

However, Oregonia and Flat Fork were the nearest I could get to Wilmington at this time because of the necessity of travelling on foot. It was a great thrill, therefore, when just before I entered high school, Dr. Austin learned of my interest in fossils and was kind enough to call upon me at home in Cincinnati.

Thus commenced an acquaintanceship of great benefit to me for I found a good friend whose encouragement and advice caused me to continue my studies and finally to adopt science as a profession. Thereafter Dr. Austin often called upon me on his visits to the city and during my vacations I now found opportunity to travel as far as Wilmington. Here, in his horse and buggy after his professional visits, we would proceed to the various early Silurian outcrops which he had discovered and made classic. We soon found other

Submitted Sept. 10, 1953.

interests in common, one of them a mutual love for watermelon, so that usually on our trips I discovered a big one stored in the buggy.

From Dr. Austin I really learned how to collect good fossils and, above all, that a large part of their value for scientific purposes was in recording their exact geologic horizons and localities. His choicest specimens were always displayed in cases in his office, all labeled with great care, but the large amount of study material which he had accumulated with little time to classify, was packed away with equally detailed labels in boxes and baskets behind and below these cases. As a result, Dr. Austin's patients couldn't help absorbing some knowledge of fossils and thereby they became active scouts for him in the discovery of new localities.

It was therefore a great personal pleasure and satisfaction when a quarter of a century after my schoolday trips with him, Dr. Austin addressed the following letter to the Secretary of the Smithsonian Institution where I had received an appointment in the department of geology soon after graduation.

"Wilmington, Ohio
July 16, 1923

"Dr. Charles D. Walcott
Secretary Smithsonian Institution
Washington, D.C.

Dear Dr. Walcott:

"I have just shipped by freight as a gift to the U.S. National Museum, twelve packing cases containing my private collection of early Silurian fossils from Clinton County, Ohio.

"The collection, containing about 25,000 specimens is composed of selected and unusually good, named specimens including a number of types, and a stratigraphic set representing the various early Silurian formations of this area in quite full detail.

"This collection is the result of my life-long efforts and being fully convinced that the National Museum is not only the best institution in the world for the preservation of such material, but also that it will fill a gap in your biologic and stratigraphic series, I take pleasure in presenting it at this time; since its safe housing in the National Museum will give me assurance while I am yet alive that its use to science will be made certain for all time.

"I may further add that Mr. Bassler and I have gone over the entire collection in full detail preparatory to packing it for shipment and have labeled it most carefully. I have also supplied him with maps and charts, as well as a detailed geologic section of the area so that there will be no question as to the exact stratigraphic horizon of every fossil.

"In conclusion, I would repeat that it will be a great pleasure and relief to know that this collection has been safely housed and fully catalogued at the U. S. National Museum during my lifetime, and also that it will become a part of the great Paleozoic collection built up by you and your associates.

"Very truly yours,

"G. M. AUSTIN."

With the arrival of the collection at Washington the work of cataloging and numbering the specimens and of distributing them in the exhibition and study series in the department of geology, was carried on actively. Hence, Dr. Austin, while on an automobile trip through the east with his family in August 1926, had the satisfaction of inspecting his fossils in their new home and of knowing that they were now at the service of students for all time to come.

His interest in geology, however, did not cease with this gift for, encouraged by friends, he recorded his special knowledge of the distribution of these fossils in a paper "Richmond Faunal Zones in Warren and Clinton Counties, Ohio," printed as Article No. 2671 in the *Proceedings of the United States National Museum*, volume 70, 1927. Here were registered the stratigraphic ranges and the type localities of many rare and interesting fossils, of which he alone had accurate knowledge, a scientific contribution which has proved most valuable in the detailed stratigraphic studies since that time.

During the course of his long professional life Dr. Austin had opportunity to observe also many facts concerning the glacial geology of his home area. Fortunately he kept ample notes of these observations and preserved the records secured from the many wells drilled in Clinton County. It followed naturally that he became the authority on underground water and the location of water supplies. This information too, which from its nature could not be duplicated, has been preserved in his volume published by Wilmington College in 1930, entitled *Surface Geology of Clinton County, Ohio.*

I have recorded above what Dr. Austin's friendship and encouragement meant to me personally, but his life is especially unique in illustrating the good that can be accomplished not only in one's profession but also in spare moments employed in the earnest and enthusiastic pursuit of an avocation.

How the Gastroscope Was Developed

The first attempts at gastroscopy were made in 1868 by Kussmaul after he watched a sword swallower. He reasoned that a tube with a lamp in it could be swallowed as easily as a sword. However, the technical problems of illumination were not solved until the early 1920's.

During the period from 1922 to 1932, Dr. Rudolf Schindler constructed a flexible gastroscope and described the endoscopic pathology of the stomach. In 1934 Doctor Schindler was invited to the University of Chicago as a visiting professor. Since then, the gastroscope has found its place in most large clinics and hospitals in America. — Henry Laurens, Jr., M.D., Salina, Kans., and Ray U. Northrip, M.D., Ada, Okla.: *J. Oklahoma State M.A.*, 47:9, January, 1954.



Official Program

for the

1954 ANNUAL MEETING
OHIO STATE MEDICAL ASSOCIATION
COLUMBUS
April 12, 13, 14 and 15, 1954

HERE are details of what is in store for physicians at the 1954 Annual Meeting, Ohio State Medical Association—topics to be discussed, names of outstanding speakers and other pertinent information.

TIME AND PLACE: Four days this year—Monday, Tuesday, Wednesday and Thursday, April 12, 13, 14 and 15. Monday will be "Specialty Society Day." The first meeting of the House of Delegates will be Monday evening. Meetings and exhibits will be in the Neil House and Deshler-Hilton Hotel—a half-square apart in downtown Columbus.

REGISTRATION: Registration Headquarters will be in the Main Lobby of the Neil House. Registration facilities will be available on Monday afternoon for those who attend Monday meetings. On Tuesday and Wednesday, Registration Headquarters will be open from 8 a. m. to 6 p. m., on Thursday, from 8 a. m. to noon. There is no registration charge. Admission to all sessions and to the exhibits will be by badge secured at Registration Headquarters. Those eligible to register are: Members of the Ohio State Medical Association (who should have 1954 Membership Cards for presentation at time of registration); physicians from other states who are members of their respective state medical societies; residents, interns, medical students, nurses, health workers, and others who are presented at Registration Headquarters by members. The Woman's Auxiliary will provide registration facilities for its members and others who are eligible for membership.



SPECIALTY SECTION PROGRAMS: The wide range of program material is indicated by the fact that 12 Sections are presenting programs. They are: Sections on Anesthesiology, General Practice, Internal Medicine, Neurological Surgery, Obstetrics and Gynecology, Ophthalmology, Otorhinolaryngology, Pediatrics, Physical Medicine,

Radiology, Surgery, and Urology. The Section on Obstetrics and Gynecology and the Section on Pediatrics will hold a joint meeting. All physicians, regardless of whether or not they belong to the specialty, are welcome to attend these sessions.

OUT-OF-STATE GUEST SPEAKERS: Ten guest speakers from other states, each an authority in his field, will participate in the program. Each will speak before a Specialty Section and again before a General Session.

GENERAL SESSIONS: Three of these sessions will be held, consisting of three and four lectures each—on Tuesday and Wednesday afternoons and on Thursday morning. Timely topics of interest in everyday practice will be discussed. See list of subjects and speakers under the chronological program.



CONFERENCE OF OFFICERS AND COMMITTEE CHAIRMEN OF COUNTY MEDICAL SOCIETIES: On Tuesday afternoon and evening, panelists will discuss some lively issues facing the medical profession as a whole today. Subjects to be discussed are: "Why a Community Health Council?"; "Grievance Committees—How They Work"; and "Making P. R. Click."

HOUSE OF DELEGATES: The policy-making and legislative body of the Association will meet twice during the Annual Meeting. The first session has been scheduled for Monday evening to allow delegates more time to attend scientific sessions. The second session will be on Thursday morning. Although only delegates may take part in the proceedings, any member of the Association is welcome to attend these meetings. Dinner and breakfast are reserved for those who are attending in an official capacity.

SCIENTIFIC EXHIBITS: Latest developments in medical research and investigation will be emphasized in these features. This is an excellent opportunity for physicians to discuss with sponsors their presentations. Ample time has been provided throughout the program for visiting Scientific Exhibits which will be in the Deshler-Hilton Hotel.

TECHNICAL EXHIBITS: These are always important education features of the Annual Meeting Program. Latest developments in pharmaceutical products, surgical instruments, therapeutic equipment and other needs of the profession will be displayed. Technical Exhibits will be in the Neil House.



SPECIALTY SOCIETY MEETINGS: Several organizations have scheduled meetings on Monday. They include the Ohio State Surgical Association, Ohio Academy of General Practice, Ohio Chapter of the American Academy of Pediatrics, Ohio Section of the American Academy of Obstetrics and Gynecology and Ohio Psychiatric Association. The Central Ohio Radiological Society will be host to the Section on Radiology on Tuesday evening.

WOMAN'S AUXILIARY: The Woman's Auxiliary to the Ohio State Medical Association will hold its annual meeting concurrently with that of the Association. Sessions will be in the Southern Hotel.

ANNUAL BANQUET: This event will be held on Wednesday evening in the Neil House with a fine dinner served in congenial surroundings. A musical program will be presented by the Ohio State University Men's Glee Club. Featured speaker will be Edward J. McCormick M. D., Toledo, President of the American Medical Association.

1954 ANNUAL MEETING

Ohio State Medical Association

Neil House and Deshler-Hilton Hotel, Columbus

MONDAY, APRIL 12

SPECIALTY SOCIETY DAY

(See Program For Details)

TIME	*EVENT*	*PLACE*
9:00 A.M. to 9:30 P.M.	OHIO STATE SURGICAL ASSOCIATION	Dining Rooms 10, 11, 12 Hilton Addition Deshler-Hilton Hotel
11:00 A.M. to 9:00 P.M.	OHIO PSYCHIATRIC ASSOCIATION	Sapphire Room Fort Hayes Hotel
3:00 to 9:00 P.M.	OHIO ACADEMY OF GENERAL PRACTICE	Parlors A and B Mezzanine Floor Deshler-Hilton Hotel
4:00 to 6:30 P.M.	OHIO CHAPTER, AMERICAN ACADEMY OF PEDIATRICS	Children's Hospital 561 South 17th Street
4:00 to 9:00 P.M.	OHIO SECTION, AMERICAN ACADEMY OF OBSTETRICS AND GYNECOLOGY	Columbus Athletic Club 136 East Broad Street
6:00 P.M.	HOUSE OF DELEGATES OF O.S.M.A.	Main Ballroom Mezzanine Floor Neil House

WHERE TO GET TICKETS FOR SPECIAL EVENTS

For some of the special events taking place during the Annual Meeting those involving luncheons or dinners—tickets may be purchased in advance by mail. Here is the information for those interested:

Annual Banquet, Wednesday evening, April 14: From Columbus Office, O. S. M. A.; price per ticket, $5.50. Check should accompany order. At O. S. M. A. Registration Headquarters during meeting.

Ohio State Surgical Association Banquet, Monday evening, April 12: From Richard E. Vance, M. D., 9 Buttles Avenue, Columbus 8; price per ticket, $4.25. Check should accompany order.

Central Ohio Radiological Society Dinner, Tuesday evening, April 13: From H. W. Bangs, M. D., 1381 West Sixth Avenue, Columbus; price per ticket, $4.50. Check should accompany order. At O. S. M. A. Registration Headquarters until noon, April 13.

Ohio Chapter, American Academy of Chest Physicians Luncheon, Wednesday noon, April 14: From Lynne E. Baker, M. D., 530 Fidelity Building, Dayton 2; price per ticket, $3.00. Check should accompany order.

Women's Medical Society of Columbus Luncheon, Wednesday noon, April 14: From Juliet Stanton, M. D., 327 E. State Street, Columbus 15; price per ticket $2.50. Check should accompany order. At O. S. M. A. Registration Headquarters prior to Wednesday noon.

(See detailed program for time and place of these events.)

1954 ANNUAL MEETING

Ohio State Medical Association

Neil House and Deshler-Hilton Hotel, Columbus

TUESDAY, APRIL 13

TIME	EVENT	PLACE
8:00 A.M.	**REGISTRATION OPENS**	Main Lobby Neil House
8:00 to 9:30 A.M.	**TOUR OF EXHIBITS**	Mezzanine Lounge and Junior Ballroom Neil House (Technical) Foyer to Main Ballroom, Deshler-Hilton Hotel (Scientific)
9:30 to 12:10 P.M.	**SECTION ON GENERAL PRACTICE**	Hall of Mirrors Hilton Addition Deshler-Hilton Hotel
9:30 A.M. to 12:00 Noon	**SECTION ON OBSTETRICS AND GYNECOLOGY** and **SECTION ON PEDIATRICS** *(Combined Session)*	Main Ballroom Mezzanine Floor Deshler-Hilton Hotel
9:30 A.M. to 12:10 P.M.	**SECTION ON OPHTHALMOLOGY**	Parlor B Mezzanine Floor Neil House
9:30 A.M. to 12:20 P.M.	**SECTION ON SURGERY**	Main Ballroom Mezzanine Floor Neil House
9:30 A.M. to 12:00 Noon	**SECTION ON UROLOGY**	Parlors A and B Mezzanine Floor Deshler-Hilton Hotel
10:00 A.M. to 4:00 P.M.	**OHIO PSYCHIATRIC ASSOCIATION**	Sapphire Room, Fort Hayes Hotel
12:30 to 2:00 P.M.	**RECESS FOR LUNCHEON AND TOUR OF EXHIBITS**	
2:00 to 3:30 P.M.	**GENERAL SESSION** **HARRIS B. SHUMACKER, JR., M. D.** **Indianapolis, Ind.** **ALLAN C. BARNES, M.D.** **Cleveland** **STEWART H. CLIFFORD, M.D.** **Brookline, Mass.**	Main Ballroom Mezzanine Floor Neil House
3:30 to 6:00 P.M.	**TOUR OF EXHIBITS**	
3:45 to 9:00 P.M.	**(Conference of Officers and Committee Chairmen of County Medical Societies. An invitational event. Will open at 3:45 P.M. in Main Ballroom, Deshler-Hilton Hotel. Buffet supper at 6:00 P.M. in Hall of Mirrors and evening session at 7:30 P.M. in Ballroom.)**	
6:00 P.M.	**JOINT MEETING OF CENTRAL OHIO RADIOLOGICAL SOCIETY AND SECTION ON RADIOLOGY** *(See page 265 for details)*	Parlor 4 Mezzanine Floor Neil House

1954 ANNUAL MEETING

Ohio State Medical Association

Neil House and Deshler-Hilton Hotel, Columbus

WEDNESDAY, APRIL 14

TIME	EVENT	PLACE
8:00 A.M.	REGISTRATION	Main Lobby Neil House
8:00 to 9:30 A.M.	TOUR OF EXHIBITS	
9:30 A.M. to 12:00 Noon	SECTION ON ANESTHESIOLOGY	Main Ballroom Mezzanine Floor Deshler-Hilton Hotel
9:30 A.M. to 12:00 Noon	SECTION ON INTERNAL MEDICINE	Main Ballroom Mezzanine Floor Neil House
9:30 A.M. to 12:00 Noon	SECTION ON NEUROLOGICAL SURGERY	Parlor 4 Mezzanine Floor Neil House
9:30 A.M. to 12:10 P.M.	SECTION ON OTORHINOLARYNGOLOGY	Parlor B Mezzanine Floor Neil House
9:30 A.M. to 12:00 Noon	SECTION ON PHYSICAL MEDICINE	Parlors A and B Mezzanine Floor Deshler-Hilton Hotel
9:30 A.M. to 12:00 Noon	SECTION ON RADIOLOGY	Hall of Mirrors Hilton Addition Deshler-Hilton Hotel
12:00 Noon to 2:00 P.M.	RECESS FOR LUNCHEON AND TOUR OF EXHIBITS	
12:15 P.M.	OHIO CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS	Dining Room 12 Hilton Addition Deshler-Hilton Hotel
12:30 P.M.	WOMEN'S MEDICAL SOCIETY OF COLUMBUS	Parlor 2 Mezzanine Floor Neil House
2:00 to 4:00 P.M.	GENERAL SESSION HENRY L. WILLIAMS, M.D. Rochester, Minn. HAROLD G. SCHEIE, M.D. Philadelphia, Pa. ELMER L. SEVRINGHAUS, M.D. Nutley, N.J. GEORGE C. PRATHER, M.D. Brookline, Mass.	Main Ballroom Mezzanine Floor Neil House
4:00 to 6:00 P.M.	TOUR OF EXHIBITS	
7:30 P.M.	ANNUAL BANQUET	Main Ballroom Mezzanine Floor Neil House

1954 ANNUAL MEETING

Ohio State Medical Association

Neil House and Deshler-Hilton Hotel, Columbus

THURSDAY, APRIL 15

TIME	EVENT	PLACE
8:00 A.M.	**REGISTRATION**	Main Lobby Neil House
8:00 A.M.	**HOUSE OF DELEGATES**	Town and Country Room Lobby Floor Neil House
8:00 to 9:30 A.M.	**TOUR OF EXHIBITS**	
9:30 A.M. to 12:00 Noon	**GENERAL SESSION** FRANK J. KRUSEN, M.D. Rochester, Minn. JOSEPH C. BELL, M.D. Louisville, Ky. URBAN H. EVERSOLE, M.D. Boston, Mass. WILLIAM LIKOFF, M.D. Philadelphia, Pa.	Main Ballroom Mezzanine Floor Neil House
12:00 Noon to 1:00 P.M.	**TOUR OF EXHIBITS — EXHIBITS CLOSE AT 1:00 P.M.**	
1:45 to 4:15 P.M.	**OHIO STATE HEART ASSOCIATION** *(See page 270 for details)*	Hall of Mirrors Hilton Addition Deshler-Hilton Hotel

RESOLUTIONS TO BE PRESENTED AT 1954 MEETING SHOULD BE SENT TO COLUMBUS FOR PUBLICATION IN JOURNAL

County Medical Societies which plan to have their delegates introduce resolutions at the 1954 Annual Meeting of the Ohio State Medical Association, April 12-15, Columbus, or individual delegates who have prepared resolutions for consideration at the Columbus meeting, should, if possible, submit copies of such resolutions to the Columbus Office so they can be published in the April issue of *The Journal.*

Copies of such resolutions should be sent to the Columbus Office on or before March 20 to insure publication in the April *Journal.*

In 1948 the House of Delegates adopted a resolution requesting that this action be taken by County Medical Societies and individual delegates.

It was pointed out in the 1948 action that this would give delegates an opportunity to know in advance the subjects to be considered through resolutions and a chance to discuss such matters with their local societies and receive instructions on matters of policy involved.

MEETINGS OF SPECIALTY SOCIETIES

MONDAY, APRIL 12

9:00 A.M.

OHIO STATE SURGICAL ASSOCIATION

Dining Rooms, 10, 11, 12, Hilton Addition
Deshler-Hilton Hotel

9:00 to 12:00

BUSINESS SESSION.

2:00 to 5:00

SCIENTIFIC PROGRAM:

2:00 to 3:00

THE MANAGEMENT OF ANEURYSMS AND ARTERIOVENOUS FISTULAS

Harris B. Shumacker, Jr., Indianapolis, Ind., Director of Surgery, Indiana University Medical Center.
Discussion to be opened by Louis G. Herrmann, M.D., Cincinnati.

3:00 to 3:30

THE EVALUATION OF RESULTS OF LUMBAR SYMPATHECTOMY FOR PERIPHERAL VASCULAR INSUFFICIENCY

William G. Eckman, M.D., Dayton.
Discussion to be opened by Claude C. Burton, M.D., Dayton.

3:30 to 4:00

THE SURGICAL TREATMENT OF COMPLICATED DIVERTICULITIS OF THE COLON

Robert A. McLemore, M.D., and William P. Montanus, M.D., Springfield.
Discussion to be opened by Scott Hill, M.D., Canton.

4:00 to 4:30

A METHOD OF TREATMENT OF FRACTURE OF THE OS CALCIS

John F. Lyons, M.D., and Ralph G. Carothers, M.D., Cincinnati.
Discussion to be opened by Robert E. S. Young, M.D., Columbus.

4:30 to 5:00

THE SURGICAL TREATMENT OF ACUTE CHOLECYSTITIS

C. W. McNamara, M.D., Toledo.
Discussion to be opened by Byron G. Shaffer, M.D., Toledo.

7:00 P.M.

Hall of Mirrors, Hilton Addition
Deshler-Hilton Hotel

BANQUET: For members of the Ohio State Surgical Association and their wives and guests; also, all other members of Ohio State Medical Association who may desire to attend.

ADDRESS: Paul R. Hawley, M.D., Chicago, Director, American College of Surgeons.

Dinner reservations may be secured in advance by writing to Richard E. Vance, M. D., Chairman of Arrangements, 9 Buttles Ave., Columbus 8. Price of dinner, $4.25.

MONDAY, APRIL 12

11:00 A.M.

OHIO PSYCHIATRIC ASSOCIATION

Sapphire Room
Fort Hayes Hotel

11:00 A.M. to 12:30 P.M.

SCIENTIFIC SESSION.

12:30 to 2:00

JOINT COUNCIL COMMITTEE LUNCHEON.

2:00 to 4:00

SCIENTIFIC SESSION.

4:00 to 6:00

GENERAL BUSINESS MEETING.

7:00 to 8:00

SOCIAL SESSION—COCKTAILS.

8:00 to 9:00

SOCIAL SESSION—BANQUET.

MONDAY, APRIL 12

3:00 P.M.

OHIO ACADEMY OF GENERAL PRACTICE

Parlors A and B, Mezzanine Floor
Deshler-Hilton Hotel

3:00 to 5:00 P.M.

GENERAL MEETING:

1. Report of all committees and a meeting of Board of Directors.
2. Report on the American Academy of General Practice Annual Scientific Assembly, March, 1954.
3. Awarding of Honorary Membership to Charles A. Doan, M.D., Dean, College of Medicine, Ohio State University, and to Stanley Dorst, M.D., Dean, University of Cincinnati College of Medicine.

7:00 to 9:00 P.M.

CONTINUATION OF AFTERNOON MEETING.

MONDAY, APRIL 12

4:00 P.M.

OHIO SECTION, AMERICAN ACADEMY OF OBSTETRICS AND GYNECOLOGY

Columbus Athletic Club
136 East Broad Street

4:00 to 5:00 P.M.

Organizational Meeting; Installation of Officers; Adoption of Constitution.

5:00 to 7:00 P.M.

Cocktail Party. Host, Columbus Obstetrical and Gynecological Society.

7:00 P.M.

Dutch Treat Dinner for members of all local obstetrical and gynecological societies and other physicians interested in obstetrics and gynecology.

Reports by representatives of local obstetrical and gynecological societies on their maternal mortality studies.

MONDAY, APRIL 12

4:00 P.M.

OHIO CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

Grand rounds at Children's Hospital, 561 South 17th Street, Columbus, under the direction of Dr. Earl Baxter.

INTESTINAL OBSTRUCTION IN INFANTS

H. Wm. Clatworthy, M.D., Columbus.

MODERN PEDIATRIC HEMATOLOGY

William A. Newton, M.D., Columbus.

Business Meeting

6:30 P.M.

Dinner at the Maramor Restaurant, 137 East Broad St., Columbus, for members of the Ohio Chapter, American Academy of Pediatrics, and their wives.

MONDAY, APRIL 12

6:00 P.M.

HOUSE OF DELEGATES

COMPLIMENTARY DINNER FOR DELEGATES, OFFICERS AND COUNCILORS, TO BE FOLLOWED BY BUSINESS SESSION

Main Ballroom, Mezzanine Floor
Neil House

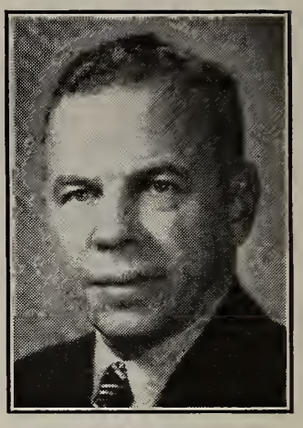
ORDER OF BUSINESS

1. Call to order by Judson D. Wilson, M.D., President of the Columbus Academy of Medicine.
2. Introduction of the President, Paul A. Davis, M.D., Akron.
3. Consideration of the minutes of the last Annual Meeting (June, 1953, issue of *The Journal.*
4. Appointment of Reference Committees by the President:
   (a) Committee on Credentials of Delegates.
   (b) Committee on President's Address.
   (c) Committee on Resolutions.
   (d) Committee on Tellers and Judges of Election.
5. Nomination and election of Committee on Nominations:
   (Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the Second Session, Thursday, 8:00 A.M., its recommendations in the form of a ticket containing nominees for constitutional offices, to be filled at this meeting, as required under the Constitution and By-Laws.)
6. Introduction of Resolutions:
   (Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committee on Resolutions, and reported back to the House of Delegates at the Thursday morning session before any action can be taken. All resolutions must be typewritten and submitted in triplicate.)
7. Announcements of meeting places of Committee on Nominations and Reference Committees by chairmen of the committees.
8. Miscellaneous business.
9. Announcements of Annual Meeting events.
10. Recess.

Guest Speakers



E. L. SEVRINGHAUS, M. D.
Nutley, N. J.



S. H. CLIFFORD, M. D.
Brookline, Mass.

TUESDAY, APRIL 13

8:00 A.M.

REGISTRATION

Main Lobby, Neil House

8:00 to 9:30

TOUR OF EXHIBITS

TUESDAY, APRIL 13

9:30 A.M.

SECTION ON GENERAL PRACTICE

Hall of Mirrors, Hilton Addition
Deshler-Hilton Hotel

H. W. Salter, M.D., Cleveland.....Chairman
J. H. Shanklin, M.D., Springfield.....Secretary

9:30 to 10:00

TECHNIQUE OF HISTORY TAKING

George H. Lemon, M.D., Toledo.

10:00 to 10:30

INDUSTRIAL DISEASES

Thomas F. Mancuso, M.D., Columbus.

10:30 to 11:00

MISTAKES IN TREATMENT OF HEART DISEASE

John W. Martin, M.D., Cleveland.

11:00 to 11:30

THE ACUTE ABDOMEN—DIAGNOSIS AND TREATMENT

R. Richard Renner, M.D., Cleveland Heights.

11:30 to 12:00

ENDOCRINE FACTORS IN OBESITY

Elmer L. Sevringhaus, M.D., Nutley, N.J., Director of Research, Hoffmann-LaRoche, Inc.; Director of Endocrinology and Metabolism, Jersey City Medical Center.

12:00 to 12:10

Business Meeting. Report of Nominating Committee. Election of Officers.

12:10 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

TUESDAY, APRIL 13

9:30 A.M.

JOINT SESSION OF SECTION ON OBSTETRICS AND GYNECOLOGY AND SECTION ON PEDIATRICS

Main Ballroom, Mezzanine Floor
Deshler-Hilton Hotel

Co-chairmen of Joint Session: Arthur G. King, M.D., Cincinnati, and Robert H. Kotte, M.D., Cincinnati.

SYMPOSIUM ON PERINATAL MORTALITY

9:30 to 9:40

RESUSCITATION OF THE NEWBORN

Jerold K. Hoerner, M.D., Dayton.

9:40 to 9:50

THE EFFECT OF ANALGESICS AND ANESTHETICS ON THE NEWBORN

Charles H. Hendricks, M.D., Columbus.

9:50 to 10:00

THE CYANOTIC INFANT

Thomas E. Shaffer, M.D., Columbus.

10:00 to 10:10

FETAL SALVAGE IN TOXEMIA OF PREGNANCY

Hyatt Reitman, M.D., Cleveland.

10:10 to 10:20

HEMATOLOGIC PROBLEMS OF THE NEWBORN

William A. Newton, M.D., Columbus.

10:20 to 10:30

THE POST-MATURE INFANT—A CLINICAL SYNDROME DUE TO PLACENTAL DYSFUNCTION

Stewart H. Clifford, M.D., Brookline, Mass., Assistant Professor of Pediatrics, Harvard Medical School; Chief of Premature Service, Children's Medical Center of Boston.

10:30 to 11:15

QUESTION AND ANSWER PERIOD.

11:15 to 12:00

Business Meetings of both Sections. Reports of Nominating Committees. Election of Officers.

12:00 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

TUESDAY, APRIL 13

9:30 A.M.

SECTION ON OPHTHALMOLOGY

Parlor B, Mezzanine Floor
Neil House

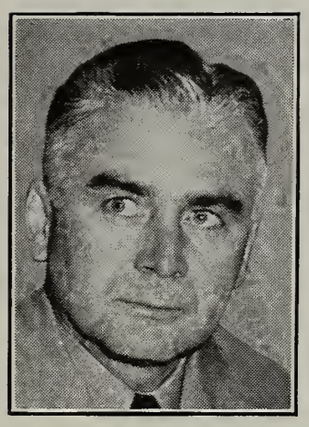
Ralph H. Miller, M.D., Cincinnati.....Chairman
Claude S. Perry, M.D., Columbus.....Secretary

9:30 to 11:20

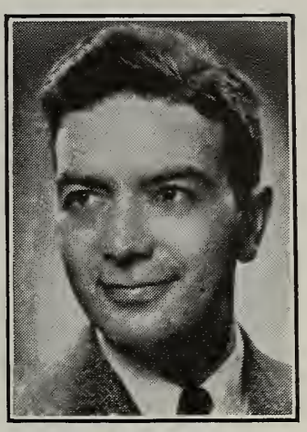
THE SURGICAL TREATMENT OF GLAUCOMA

Harold G. Scheie, M.D., Philadelphia, Pa., Professor of Ophthalmology, Hospital of the University of Pennsylvania; Central Office Chief Consultant in Ophthalmology, Veterans Administration.

Guest Speakers



HAROLD G. SCHEIE, M. D.
Philadelphia



H. B. SHUMACKER, Jr., M. D.
Indianapolis

11:20 to 11:40

QUESTION AND ANSWER PERIOD.

11:40 to 12:00

THE USE OF RADIOACTIVE PHOSPHORUS IN THE DETECTION OF OCULAR TUMORS

Roscoe J. Kennedy, M.D., Cleveland.

12:00 to 12:10

Business Meeting. Report of Nominating Committee. Election of Officers.

12:10 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

TUESDAY, APRIL 13

9:30 A.M.

SECTION ON SURGERY

Main Ballroom, Mezzanine Floor
Neil House

Donald M. Glover, M.D., Cleveland.....Chairman
Marcus J. Magnussen, M.D., Gallipolis....Secretary

9:30 to 10:20

SAFE ANESTHESIA (Panel Discussion)

R. A. Hingson, M.D., Cleveland.
J. J. Jacoby, M.D., Columbus.
R. S. Dinsmore, M.D., Cleveland.
Vinton E. Siler, M.D., Cincinnati.

10:20 to 10:40

THE MANAGEMENT OF FACIAL FRACTURES

Bruce C. Martin, M.D., Columbus.

10:40 to 11:00

COMPLICATIONS OF GASTRIC SURGERY

Stanley O. Hoerr, M.D., Cleveland.

11:00 to 11:20

PANCREATITIS

Robert M. Zollinger, M.D., Columbus.

(Continued on next page)

11:20 to 11:50

SURGICAL CONSIDERATIONS IN THE TREATMENT OF INJURIES AND DISEASES OF PERIPHERAL ARTERIES

Harris B. Shumacker, Jr., M.D., Indianapolis, Ind., Professor of Surgery, Indiana University Medical School.

11:50 to 12:10

DISEASES AND INJURIES OF THE PERIPHERAL ARTERIES (Panel Discussion)

Harris B. Shumacker, Jr., M.D., Indianapolis, Ind.
F. A. Simeone, M.D., Cleveland.
Louis G. Herrmann, M.D., Cincinnati.

12:10 to 12:20

Business Meeting. Report of Nominating Committee. Election of Officers.

12:20 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

TUESDAY, APRIL 13

9:30 A.M.

SECTION ON UROLOGY

Parlors A and B, Mezzanine Floor
Deshler-Hilton Hotel

N. L. Burrell, M.D., Springfield.....Chairman
E. F. Ockuly, M.D., Toledo.....Secretary

9:30 to 10:15

SURGICAL TREATMENT OF RENAL CYSTS

George C. Prather, M.D., Brookline, Mass., Head of Department of Urology, Beth Israel Hospital, and Consultant in Urology, Boston Lying-In Hospital, Boston.

10:15 to 11:45

PANEL DISCUSSION OF CASE PRESENTATIONS

Panelists: George C. Prather, M. D., Brookline, Mass.; William J. Engel, M. D., Cleveland; William N. Taylor, M. D., Columbus; T. Brent Wayman, M. D., Cincinnati; Ralph W. Eddy, M. D., Cincinnati.

11:45 to 12:00

Business Meeting. Report of Nominating Committee. Election of Officers.

12:30 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

TUESDAY, APRIL 13

10:00 A.M.

OHIO PSYCHIATRIC ASSOCIATION

Sapphire Room
Fort Hayes Hotel

10:00 A.M. to 12:00 Noon

SCIENTIFIC SESSION.

12:00 Noon to 2:00 P.M.

LUNCHEON.

2:00 to 4:00

SCIENTIFIC SESSION.

TUESDAY, APRIL 13

2:00 P.M.

GENERAL SESSION

Main Ballroom, Mezzanine Floor
Neil House

Presiding: Louis G. Herrmann, M.D., Cincinnati, Member, Committee on Scientific Work.

2:00 to 2:30

THE MANAGEMENT OF VENOUS THROMBOSIS AND ITS CONSEQUENCES

Harris B. Shumacker, Jr., M.D., Indianapolis, Ind., Professor of Surgery, University of Indiana School of Medicine.

2:30 to 3:00

RECENT TRENDS IN THE MANAGEMENT OF TOXEMIA OF PREGNANCY

Allan C. Barnes, M. D., Cleveland, Arthur H. Bill Professor of Obstetrics and Gynecology; Chairman of the Department of Obstetrics and Gynecology, Western Reserve University School of Medicine.

3:00 to 3:30

COMMON PROBLEMS IN THE NEWBORN INFANT

Stewart H. Clifford, M.D., Brookline, Mass., Assistant Professor of Pediatrics, Harvard Medical School; Chief of Premature Service, Children's Medical Center of Boston.

3:30 to 6:00

TOUR OF EXHIBITS

TUESDAY, APRIL 13

3:45 P.M.

CONFERENCE OF OFFICERS AND COMMITTEE CHAIRMEN OF COUNTY MEDICAL SOCIETIES

(By invitation)

Main Ballroom, Mezzanine Floor
Deshler-Hilton Hotel

Presiding: Paul A. Davis, M.D., Akron, President, Ohio State Medical Association.

PANEL DISCUSSIONS

3:45 to 4:45

WHY A COMMUNITY HEALTH COUNCIL?

Moderator: Edmond K. Yantes, M.D., Wilmington, Chairman, Committee on Rural Health, Ohio State Medical Association.

Panelists:

Richard C. Jones, M.D., Logan, Secretary, Hocking County Medical Society.

Mrs. Litta K. Roberson, Columbus, Supervisor, Women's Activities, Ohio Farm Bureau Federation.

Sewall O. Milliken, M.P.H., Columbus, Chief, Public Health Education Division, Ohio Department of Health.

(Continued on next page)

Frederick J. Dineen, M.D., Painesville, Chairman, Committee on Public Relations, Lake County Medical Society.

4:45 to 5:30

GRIEVANCE COMMITTEES—HOW THEY WORK

Moderator: Merrill D. Prugh, M.D., Dayton, President-Elect, Ohio State Medical Association.

Panelists:

John H. Budd, M.D., Cleveland, President, Cleveland Academy of Medicine.

Lawrence N. Irvin, M.D., Lima, Former Secretary, Academy of Medicine of Lima and Allen County.

David T. Curtis, M.D., Toledo, Former Chairman, Professional Relations Committee, Academy of Medicine of Toledo and Lucas County.

6:00

Reception and Buffet Supper, Hall of Mirrors, Deshler-Hilton Hotel.

7:30 to 8:30

Main Ballroom, Mezzanine Floor
Deshler-Hilton Hotel

MAKING P. R. CLICK

Moderator: Frank L. Shively, Jr., M.D., Dayton, Former Chairman, Committee on Public Relations, Montgomery County Medical Society.

Panelists:

Delbert J. Parsons, M. D., Springfield, Former Chairman, Committee on Public Relations, Clark County Medical Society.

Millard C. Beyer, M. D., Akron, Past-President, Summit County Medical Society.

Edwin H. Artman, M.D., Chillicothe, Chairman, Committee on Public Relations, Ross County Medical Society.

Theodore Berg, M.D., Elyria, Former Chairman, Committee on Public Relations, Lorain County Medical Society.

TUESDAY, APRIL 13

6:00 P.M.

JOINT MEETING OF CENTRAL OHIO RADIOLOGICAL SOCIETY AND SECTION ON RADIOLOGY

Parlor 4, Mezzanine Floor
Neil House

6:00 to 7:00 P.M.

SOCIAL HOUR.

7:00 P.M.

DINNER.

Tickets, at $4.50 each, may be secured in advance by writing to Dr. H. W. Bangs, 1381 West Sixth Ave., Columbus; or may be purchased at the registration desk until 12:00 Noon, April 13.

MICRO-RADIOLOGY—
A SPECIAL PROBLEM IN RADIOLOGY

Isadore Meschan, M.D., University Hospital, Little Rock, Arkansas.

WEDNESDAY, APRIL 14

8:00 A.M.

REGISTRATION

Main Lobby, Neil House

8:00 to 9:30

TOUR OF EXHIBITS

WEDNESDAY, APRIL 14

9:30 A.M.

SECTION ON ANESTHESIOLOGY

Main Ballroom, Mezzanine Floor
Deshler-Hilton Hotel

B. B. Sankey, M.D., Cleveland.....Chairman
J. J. Jacoby, M.D., Columbus.....Secretary

9:30 to 9:45

IMPORTANCE OF BLOOD VOLUME STUDIES IN POOR RISK PATIENTS

John Jones, M.D., Columbus.

9:50 to 10:15

EVALUATION OF PROGRESS IN ANESTHESIA SERVICE

R. A. Hingson, M.D., and R. J. Whitacre, M.D., Cleveland.

10:25 to 10:40

RESPIRATORY FUNCTION TESTS

Henry A. Zimmerman, M.D., Cleveland.

10:45 to 11:00

LUMBAR PUNCTURE HEADACHE

Urban H. Eversole, M.D., Boston, Mass., Director, Department of Anesthesiology, Lahey Clinic; Past-President, American Society of Anesthesiologists.

11:00 to 11:10

Business Meeting. Report of Nominating Committee. Election of Officers.

11:10 to 11:40

BECK OPERATIONS FOR CORONARY DISEASE

I. Clinical Considerations
Bernard Brofman, M.D., Cleveland.
II. Anesthesia Management
Sidney Katz, M.D., Cleveland.

11:45 to 11:55

ROLE OF BRONCHOLYTIC AGENTS IN TREATMENT OF RESPIRATORY PROBLEMS

Carolyn H. Ziegler, M.D., Columbus.

12:00 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

Order your tickets in advance for the Annual Banquet by sending $5.50 per ticket to the O. S. M. A. Headquarters Office in Columbus.

WEDNESDAY, APRIL 14

9:30 A.M.

SECTION ON INTERNAL MEDICINE

Main Ballroom, Mezzanine Floor
Neil House

Fay A. LeFevre, M.D., Cleveland.....Chairman
Maurice A. Schnitker, M.D., Toledo.....Secretary

9:30 to 10:00

RECENT DEVELOPMENTS IN THE CHEMOTHERAPY OF TUBERCULOSIS

J. Park Biehl, M.D., Cincinnati.

10:00 to 10:30

TREATMENT OF INTRACTABLE ULCERATIVE COLITIS

Rupert B. Turnbull, Jr., M.D., Cleveland.

10:30 to 11:00

MEDICAL ASPECTS OF CARDIAC SURGERY

William Likoff, M.D., Philadelphia, Pa., Associate Professor of Medicine, Hahnemann Medical College; Cardiologist to Bailey Thoracic Clinic.

11:00 to 11:15

Business Meeting. Report of Nominating Committee. Election of Officers.

11:15 to 12:00

TREATMENT OF HYPERTENSION
(Panel Discussion)

Moderator: Robert D. Taylor, M.D., Cleveland.
Discussants: David C. Humphrey, M.D., and Walter H. Pritchard, M.D., Cleveland; William B. Leffler, M.D., Marion.

12:00 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

WEDNESDAY, APRIL 14

9:30 A.M.

SECTION ON NEUROLOGICAL SURGERY

Parlor 4, Mezzanine Floor
Neil House

Harry E. LeFever, M.D., Columbus.....Chairman
Charles W. Elkins, M.D., Cleveland.....Secretary

SYMPOSIUM ON INTRACRANIAL HEMORRHAGE

9:30 to 9:55

INDICATIONS AND TECHNIQUE OF CEREBRAL ANGIOGRAPHY

Curwood R. Hunter, M.D., Cincinnati.

9:55 to 10:20

CEREBRAL VASCULAR ANOMALIES

Charles W. Elkins, M.D., Cleveland.

10:20 to 10:40

THE SURGICAL TREATMENT OF APOPLEXY

Daniel Osher, M.D., Cincinnati.

Guest Speakers



U. H. EVERSOLE, M. D.
Boston



WILLIAM LIKOFF, M. D.
Philadelphia

10:40 to 11:05

EPIDURAL HEMORRHAGE

Kenneth H. Abbott, M.D., Columbus.

11:05 to 11:30

SUBDURAL HEMORRHAGE

W. James Gardner, M.D., Cleveland.

11:30 to 11:50

QUESTION AND ANSWER PERIOD.

11:50 to 12:00

Business Meeting. Report of Nominating Committee. Election of Officers.

12:00 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

WEDNESDAY, APRIL 14

9:30 A.M.

SECTION ON OTORHINOLARYNGOLOGY

Parlor B, Mezzanine Floor
Neil House

Clyde G. Chamberlin, M.D., Hamilton.....Chairman
E. W. Harris, M.D., Columbus.....Secretary

9:30 to 10:30

VERTIGO

Henry L. Williams, M.D., Rochester, Minn., Professor of Otolaryngology and Rhinology, Mayo Foundation Graduate School, University of Minnesota; Head of Section on Otolaryngology and Rhinology, Mayo Clinic.

10:30 to 11:00

PHYSIOLOGICAL ASPECTS OF RHINOPLASTY

Trent W. Smith, M.D., Columbus.

11:00 to 11:30

MANAGEMENT OF EPISTAXIS

William H. Evans, M.D., Youngstown.

11:30 to 12:00

QUESTION AND ANSWER PERIOD.

12:00 to 12:10

Business Meeting. Report of Nominating Committee. Election of Officers.

12:10 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

WEDNESDAY, APRIL 14

9:30 A.M.

SECTION ON PHYSICAL MEDICINE

Parlors A and B, Mezzanine Floor
Deshler-Hilton Hotel

Walter M. Solomon, M.D., Cleveland.....Chairman
Herman J. Bearzy, M.D., Dayton.....Secretary

9:30 to 10:00

LABORATORY STUDIES ON THE USE OF ULTRASONICS IN MEDICINE

Frank H. Krusen, M.D., Rochester, Minn., Professor of Physical Medicine and Rehabilitation, Mayo Foundation of the University of Minnesota; Head of Section on Physical Medicine and Rehabilitation, Mayo Clinic.
Discussant: Paul A. Nelson, M.D., Cleveland—10 minutes.

10:00 to 10:20

EFFECTIVE CARE OF THE HEMIPLEGIC

Herman J. Bearzy, M.D., Dayton.
Discussant: Bert A. Treister, M.D., Cleveland—5 minutes.

10:20 to 10:40

THE TREATMENT OF OSTEOARTHRITIS OF THE CERVICAL SPINE

Walter J. Zeiter, M.D., and Paul A. Nelson, M.D., Cleveland.
Discussant: Roger Q. Davis, M.D., Akron—5 minutes.

10:40 to 11:10

CIVILIAN HOSPITALS AS REHABILITATION CENTERS

Ralph E. Worden, M.D., Columbus.
Discussant: Keith C. Keeler, M.D., Akron—5 minutes.

11:10 to 11:30

HIP FRACTURES—POSTOPERATIVE THERAPY

Joseph E. Brown, M.D., Cleveland.
Discussant: J. D. Wilson, M.D., Columbus—5 minutes.

11:30 to 11:50

RECENT ADVANCES IN THE DIAGNOSIS OF PERIPHERAL NERVE LESIONS

Harry T. Zankel, M.D., Cleveland.
Discussant: Shelby G. Gamble, M.D., Columbus—5 minutes.

11:50 to 12:00

Business Meeting. Report of Nominating Committee. Election of Officers.

12:00 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

WEDNESDAY, APRIL 14

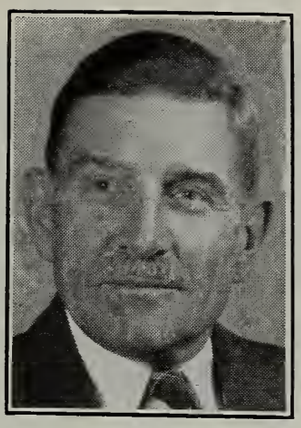
9:30 A.M.

SECTION ON RADIOLOGY

Hall of Mirrors, Hilton Addition
Deshler-Hilton Hotel

William H. Carter, M.D., Columbus.....Chairman
Frank A. Riebel, M.D., Columbus.....Secretary

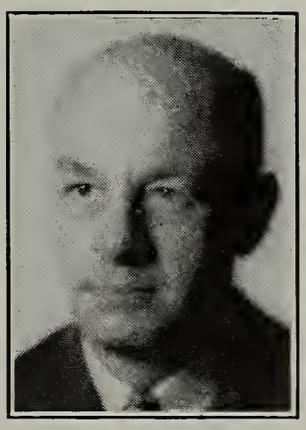
Guest Speakers



JOSEPH C. BELL, M. D.
Louisville, Ky.



FRANK H. KRUSEN, M. D.
Rochester, Minn.



G. C. PRATHER, M. D.
Brookline, Mass.



H. L. WILLIAMS, M. D.
Rochester, Minn.

9:30 to 9:45

FRACTURE OF THE PROMONTORY OF THE CALCANEUS

Arnold D. Piatt, M.D., Newark.

9:45 to 10:15

TUMORS AND GRAFTS OF THE FACIAL BONES

Clifford L. Kiehn, M.D., Cleveland.

10:15 to 10:45

INTRAVENOUS UROGRAPHY—INDICATIONS AND CONTRAINDICATIONS—CONTRAST MEDIA—REACTIONS

Joseph C. Bell, M.D., Louisville, Ky., Professor of Roentgenology, University of Louisville School of Medicine; Chief, Department of Radiology, Norton Memorial Infirmary.

10:45 to 11:45

FILM READING SESSION

Moderator: George R. Krause, M.D., Cleveland.
Panelists: Clarence E. Ash, M.D., Marietta; Paul A. Jones, M.D., Zanesville; Fred F. Somma, M.D., Akron; Jacob Weinberger, M.D., Gallipolis.

11:45 to 12:00

Business Meeting. Report of Nominating Committee. Election of Officers.

12:00 to 2:00

RECESS FOR TOUR OF EXHIBITS AND LUNCHEON

Ohio State University Men's Glee Club



One of the most popular singing groups in this part of the country will entertain physicians and their guests at the Annual Banquet on Wednesday evening, April 14. It is the Glee Club of Ohio State University, under the able direction of Professor Norman Staiger, of the School of Music. Although closely associated with the School of Music, the group traditionally draws its talent from the entire student body.

WEDNESDAY, APRIL 14

ANNUAL MEETING OF OHIO CHAPTER AMERICAN COLLEGE OF CHEST PHYSICIANS

Dining Room No. 12
Hilton Addition
Deshler-Hilton Hotel

Lynne E. Baker, M.D., Dayton ..... President
Harold H. Brueckner, M. D., Canton .. Secy.-Treas.

12:15 P.M.

LUNCHEON TO BE FOLLOWED BY BUSINESS SESSION

Tickets at $3.00 each may be secured in advance by writing to Dr. Lynne E. Baker, 530 Fidelity Building, Dayton 2, Ohio.

SURGERY IN THE DIAGNOSIS OF PULMONARY DISEASES

Neil C. Andrews, M.D., Columbus, Chief of Surgery, Ohio Tuberculosis Hospital, Columbus.

WEDNESDAY, APRIL 14

2:00 P.M.

GENERAL SESSION

Main Ballroom, Mezzanine Floor
Neil House

Presiding: Paul A. Davis, M.D., Akron, President, Ohio State Medical Association.

2:00 to 2:30

THE HEADACHE PROBLEM

Henry L. Williams, M.D., Rochester, Minn., Professor of Otolaryngology and Rhinology, Mayo Foundation Graduate School, University of Minnesota; Head of the Section on Otolaryngology and Rhinology, Mayo Clinic.

2:30 to 3:00

RETINAL CHANGES OF HYPERTENSION AND ARTERIOLARSCLEROSIS

Harold G. Scheie, M.D., Philadelphia, Pa., Professor of Ophthalmology, Hospital of the

University of Pennsylvania; Central Office Chief Consultant in Ophthalmology, Veterans Administration.

3:00 to 3:30

PRESCRIBING ADEQUATE NUTRITION

Elmer L. Sevringhaus, M.D., Nutley, N.J., Director of Research, Hoffmann-LaRoche, Inc.; and Director of Endocrinology and Metabolism, Jersey City Medical Center.

3:30 to 4:00

UROLOGICAL PROBLEMS DURING PREGNANCY

George C. Prather, M.D., Brookline, Mass., Head of Department of Urology, Beth Israel Hospital, and Consultant in Urology, Boston Lying-In Hospital, Boston.

4:00 to 6:00

TOUR OF EXHIBITS

WEDNESDAY, APRIL 14

7:30 P.M.

ANNUAL BANQUET

Main Ballroom, Mezzanine Floor
Neil House

Musical Program: Ohio State University Men's Glee Club.
Presentation of Distinguished Service Awards.
Address: Edward J. McCormick, M.D., Toledo; President, American Medical Association.

THURSDAY, APRIL 15

8:00 A.M.

REGISTRATION

Main Lobby, Neil House

8:00 to 9:30

TOUR OF EXHIBITS

THURSDAY, APRIL 15

8:00 A.M.

HOUSE OF DELEGATES

COMPLIMENTARY BREAKFAST FOR MEMBERS OF THE HOUSE OF DELEGATES TO BE FOLLOWED BY THE FINAL BUSINESS SESSION

Town and Country Room, Main Lobby
Neil House

ORDER OF BUSINESS

1. Consideration of unfinished business from Monday's session of the House of Delegates.
2. Reports of Reference Committees:
   (a) Committee on President's Address.
   (b) Committee on Resolutions.
3. Election of President-Elect. Nominations from the floor.
4. Report of Committee on Nominations:
   (a) **Election of members of The Council.** (Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in the even-numbered years.) To be elected:

   First District—(Incumbent, D. W. Heusinkveld, M.D., Cincinnati.)

   Third District—(Incumbent, James R. Jarvis, M.D., Van Wert.)

   Fifth District—(Incumbent, Charles L. Hudson, M.D., Cleveland.)

   Seventh District—(Incumbent, R. J. Foster, M.D., New Philadelphia.) (Ineligible for re-election, having served the maximum time on The Council as provided in the Constitution and By-Laws of the Association.)

   Ninth District — (Incumbent, C. L. Pitcher, M.D., Portsmouth.)

   Eleventh District—(Incumbent, John S. Hattery, M.D., Mansfield.) (Ineligible for re-election, having served the maximum time on The Council as provided in the Constitution and By-Laws of the Association.)

   (b) **Election of Delegates and Alternates to the American Medical Association**—four Delegates and four Alternates to be elected, each for a two-year term starting January 1, 1955, in compliance with the Constitution and By-Laws of the American Medical Association.

   The following incumbent Delegates and Alternates will serve for the remainder of 1954, their terms expiring December 31, 1954, and they may be considered by

(Continued on next page)

Banquet Speaker



EDWARD J. McCORMICK, M. D., Toledo
President, American Medical Association

the nominating committee for two-year terms starting January 1, 1955:

Carl A. Lincke, M.D., Carrollton (Delegate)
H. M. Platter, M.D., Columbus (Alternate)

Wm. M. Skipp, M.D., Youngstown (Delegate)
C. E. Hufford, M.D., Toledo (Alternate)

George A. Woodhouse, M.D., Pleasant Hill (Delegate)
Roy S. Binkley, M. D., Dayton (Alternate)

Herbert B. Wright, M.D., Cleveland (Delegate)
Fred W. Dixon, M.D., Cleveland (Alternate)

5. Installation of officers for 1954-1955.
6. Submission of committee appointments by the new President for confirmation by the House of Delegates.
7. Unfinished or new business.
8. Adjournment.

THURSDAY, APRIL 15

9:30 A.M.

GENERAL SESSION

Main Ballroom, Mezzanine Floor
Neil House

Presiding: A. Carlton Ernstene, M.D., Cleveland, Chairman, Committee on Scientific Work.

9:30 to 10:15

PHYSICAL MEDICINE AND REHABILITATION FOR CHRONIC ILLNESS

Frank J. Krusen, M.D., Rochester, Minn., Professor of Physical Medicine and Rehabilitation, Mayo Foundation of the University of Minnesota; Head of the Section on Physical Medicine and Rehabilitation, Mayo Clinic.

10:15 to 10:45

RADIOLOGICAL PROBLEMS IN TRAUMA OF HEAD AND NECK

Joseph C. Bell, M.D., Louisville, Ky., Professor of Roentgenology, University of Louisville School of Medicine; Chief, Department of Radiology, Norton Memorial Infirmary.

10:45 to 11:15

ANESTHESIA PROBLEMS IN THE GERIATRIC PATIENT

Urban H. Eversole, M.D., Boston, Mass., Director, Department of Anesthesiology, Lahey Clinic; Past-President, American Society of Anesthesiologists.

11:15 to 12:00

NEWER CONCEPTS OF CORONARY CIRCULATION

William Likoff, M.D., Philadelphia, Pa., Associate Professor of Medicine, Hahnemann Medical College; Cardiologist to Bailey Thoracic Clinic.

12:00 to 1:00

TOUR OF EXHIBITS

(Exhibits close at 1:00 P.M.)

ANNUAL MEETING
OHIO STATE HEART ASSOCIATION

THURSDAY, APRIL 15

Deshler-Hilton Hotel
Hall of Mirrors, Hilton Addition

1:45 P.M.

Session for Members of the Medical Profession.
Presiding: R. W. Kissane, M.D., Columbus, President-Elect.

1:45 to 2:05

HYPERTENSIVE HEART DISEASE

R. Franklin Jukes, M.D., Akron.
Discussion—5 minutes.

2:05 to 2:30

CORONARY PULMONALE HEART DISEASE

Joseph M. Ryan, M.D., Columbus.
Discussion—5 minutes.

2:30 to 2:50

CARDIAC SURGERY

Donald B. Effler, M.D., Cleveland.
Discussion—5 minutes.

2:50 to 3:10

CONGESTIVE HEART FAILURE

Gordon M. Todd, M.D., Toledo.
Discussion—5 minutes.

3:10 to 3:30

SYPHILITIC HEART DISEASE

Roy W. Scott, M.D., Cleveland.
Discussion—5 minutes.

3:30 to 3:50

ARTERIOSCLEROTIC HEART DISEASE

J. Harold Kotte, M.D., Cincinnati.
Discussion—5 minutes.

1:45 P.M.

Deshler-Hilton Hotel
(Room to be assigned)

Public Health Session on Heart Disease and the School Age Child.

MODERATORS:

Mrs. O. W. Haulman, Youngstown, Executive Secretary, Youngstown Area Heart Association.
Mr. Sewall O. Milliken, Columbus, Director of Health Education, Ohio Department of Health.
Mr. Hart F. Page, Columbus, Assistant Director of Public Relations, Ohio State Medical Association.

PHYSICAL ASPECTS

Bernard A. Schwartz, M.D., Cincinnati, Assistant Clinical Professor of Medicine, University of Cincinnati College of Medicine.

PSYCHOLOGICAL ASPECTS

Thomas E. Shaffer, M.D., Columbus, Professor of Pediatrics, Ohio State University College of Medicine.

(Continued on next page)

THE NURSE

Mrs. E. L. Weden, Jr., R.N., Youngstown, Coordinator of Community Service, Youngstown Area Heart Association.

THE PARENT

Mrs. Harold F. Marsh, Columbus, Health Service Chairman, Ohio Congress of Parents and Teachers.

THE TEACHER

Wesley P. Cushman, Ph.D., Columbus, Assistant Professor of Health and Physical Education, Ohio State University.

THE HEALTH DEPARTMENT

Harry Wain, M.D., Health Commissioner, Mansfield and Richland County, Mansfield.

Women's Medical Society of Columbus

A luncheon for all women physicians attending the Ohio State Medical Association Annual Meeting will be sponsored by the Women's Medical Society of Columbus. It will be held at 12:30 P. M., Wednesday, April 14, in Parlor No. 2, Mezzanine Floor, Neil House.

Tickets, at $2.50 each, may be purchased by mail from Dr. Juliet Stanton, 327 East State Street, Columbus 15, or at the Registration Headquarters, Ohio State Medical Association, Main Lobby, Neil House, on or before Wednesday Noon, April 14.

Columbus Center Processes Blood At Lowest Cost in Nation

The Columbus Regional Blood Center recruited donors, collected, processed and distributed blood at the lowest cost of any of the 45 National Blood Centers in the United States during 1953.

The production cost per pint of blood here to the Red Cross was $3.70. The next two lowest centers were Charlotte, N. C., at $3.88 per pint and Washington, D. C., $4.07 per pint.

In the Cleveland Blood Center the cost was $4.77 and at the Ft. Wayne, Ind., Center it was $6.26. In the New York Blood Center, blood was collected at a cost of $6.40. Highest cost of all centers was in New Orleans at $10.29 per pint.

Alfred L. Baron, executive director of the Franklin County Red Cross, in making the announcement at a meeting of the board of directors, said that the low cost of blood to the Red Cross in the Columbus Regional area is due to the careful management of the Blood Program and the many hours of service given by members of the Red Cross Volunteer Service Groups and the "fine volunteer service" given to the Blood Program by volunteer physicians and registered nurses.

Proposals To Amend By-Laws of State Association

The following resolution, proposing to amend the By-Laws of the Ohio State Medical Association, was adopted by the Summit County Medical Society on February 8, 1954, and will be presented to the House of Delegates, for action, at the 1954 Annual Meeting, April 12-15, in Columbus:

"WHEREAS, there are certain cases of hardship wherein there is at present no provision for remission of dues and assessments, and

"WHEREAS, there is no uniformity in regard to hardship cases between American Medical Association and Ohio State Medical Association,

"BE IT RESOLVED, that the By-Laws of the Ohio State Medical Association be amended in the following particulars:

"1. The second (2nd) paragraph of Chapter I, Section 4 of the By-Laws reading:

" 'Provided, however, that a doctor of medicine who is not engaged in active practice because of age or disability and who was a member in good standing of this Association at the time of his retirement from active practice shall be exempt from the payment of dues and assessments in this Association, providing he requests such exemption and such request is approved in writing by the secretary-treasurer of his component society. Provided, further, that The Council of this Association shall have the authority to promulgate regulations providing for the waiver of dues and assessments for members entering active military service on a temporary basis in times of national emergency,' be repealed.

"2. There be added to Chapter I, Section 4 of the By-Laws, the following:

"The Council of this Association shall have the authority to excuse the following members from payment of dues and assessments:

"(a) A member for whom the payment of dues would be a financial hardship by reason of physical disability or illness.

"(b) A member for whom payment of dues would be a financial hardship for reasons other than those set forth in the preceding paragraph (a), provided such fact be affirmed by the Secretary of the Member's component Society.

"(c) A member not engaged in active practice because of age or disability, provided such member was in good standing in this Association at the time of his retirement from active practice and provided such member requests such exemption in writing and such request be approved in writing by the Secretary-Treasurer of his component Society.

"(d) Members entering active Military Service on a temporary basis.

"The Council of this Association shall have authority to promulgate regulations governing the remission of dues and assessments of members under the foregoing categories."

DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
FIRST DISTRICT		
ADAMS	S. J. Ellison	Kurt Platschik
BROWN		
BUTLER	C. T. Atkinson	William U. Neel
	Neil Millikin	John F. Borelli
CLERMONT	A. A. Gruber	John T. Crone
CLINTON	E. K. Yantes	R. R. Buchanan
HAMILTON	Richard D. Bryant	Charles D. Bahl
	Edward C. Elsey	Joseph G. Crotty
	Harry L. Fry	John W. Devanney, Jr.
	Elmer R. Maurer	John G. Fleming
	John H. Payne	Harry K. Hines
	W. O. Ramey	J. Robert Hudson
	R. C. Rothenberg	Edgar S. Lotspeich
	Louis P. Stickley	Virgil A. Plessinger
	Foster M. Williams	Carl F. Vilter
	Robert M. Woolford	Edward Woliver
HIGHLAND	John G. Anderson	Robert G. Claeys
WARREN	O. L. Layman	James H. Arnold
SECOND DISTRICT		
CHAMPAIGN	I. Miller	V. R. Frederick
CLARK	Martin J. Cook	E. W. Schilke
	R. M. Turner	J. H. Shanklin
DARKE	Maurice M. Kane	P. H. Mulder
GREENE	H. C. Messenger	P. D. Espey
MIAMI	Dale A. Hudson	
MONTGOMERY	A. W. Carley	L. E. Baker
	R. C. Doan	R. M. Craig
	R. D. Dooley	W. H. Hanning
	H. M. James	R. E. Pumphrey
	T. L. Light	Ned D. Shepard
PREBLE	E. P. Trittschuh	C. J. Brian
SHELBY	George J. Schroer	H. E. Crimm
THIRD DISTRICT		
ALLEN	E. B. Young	T. D. Allison
AUGLAIZE	Guy E. Noble	T. H. Will
CRAWFORD	E. C. Brandt	L. A. Swinehart
HANCOCK	Frank M. Wiseley	Robert E. Traul
HARDIN	Floyd M. Elliott	Raymond G. Schutte
LOGAN	H. L. Mikesell	D. W. Beach
MARION	John T. Boxwell	
MERCER	Julius Schwieger	Robert M. Fell
SENECA	R. F. Machamer	P. J. Leahy
VAN WERT	H. D. Underwood	Edwin W. Burnes
WYANDOT		
FOURTH DISTRICT		
DEFIANCE	D. J. Slosser	H. J. Wenzinger
FULTON	C. S. Kellogg	William J. Neal
HENRY	R. L. Gilson	Thomas W. Quinn
LUCAS	C. L. Felker	W. A. Baird
	C. R. Forrester	M. E. Green
	D. C. Frick	J. L. Kobacker
	F. F. Rawling	H. E. Smith
	G. H. Start	C. S. Wohl
OTTAWA	George A. Boon	C. R. Wood
PAULDING	D. E. Farling	K. A. Pritchard
PUTNAM	A. P. Daniel	J.R.Echelbarger
SANDUSKY	R. R. Wilson	Howard A. Yost
WILLIAMS	John R. Riesen	Paul G. Meckstroth
WOOD	Frederick Price	R. A. Peatee
FIFTH DISTRICT		
ASHTABULA	P. J. Collander	S. R. Burroughs
CUYAHOGA	F. L. Browning	J. O. Barr
	J. K. Doran	J. H. Budd
	W. J. Engel	H. D. Fowler, Sr.
	H. A. Haller	S. O. Hoerr
	J. B. Hazard	G. R. Krause
	W. L. Huffman	M. H. Lambright, Jr.
	C. R. Jablonoski	R. H. Lechner
	F. R. Kelly	W. H. McGaw
	B. B. Larsen	J. W. Martin
	C. R. Lulenski	T. A. Shehan
	P. A. Mielcarek	
	G. W. Petznick	
	J. M. Rossen	
	H. W. Salter	
	P. J. Schildt	
	E. W. Shannon	
	G. A. Tischler	
	R. J. Whitacre	
GEAUGA	H. E. Shafer	W. C. Corey
LAKE	M. G. Carmody	B. S. Park

Counties	Delegates	Alternates
SIXTH DISTRICT		
COLUMBIANA	J. A. Fraser	P. H. Beaver
MAHONING	M. W. Neidus	E. R. McNeal
	S. W. Ondash	Asher Randell
	Wm. M. Skipp	F. G. Schlecht
PORTAGE		
STARK	R. H. Clunk	Ian B. Hamilton
	L. L. Dowell	J. R. Rohrbaugh
	W. L. Yahraus	C. V. Smith
SUMMIT	A. William Friend	H. Willard Allison
	Donald I. Minnig	Paul E. Cheek
	Carl C. Nohe	Arthur Dobkin
	Edgar C. Pickard	Robert E. Williams
TRUMBULL	A. L. Williamson	S. J. Shapiro
SEVENTH DISTRICT		
BELMONT	Peter Lancione	James H. Carson
CARROLL	T. J. Atchison	G. C. Dowell
COSHOCTON	W. R. Agricola	J. C. Briner
HARRISON	D. L. Tippett	D. C. Pettay
JEFFERSON		
MONROE	A. R. Burkhart	
TUSCARAWAS	H. E. Reed	P. W. Ebert
EIGHTH DISTRICT		
ATHENS	L. I. Goldberg	E. A. Sprague
FAIRFIELD	L. E. Stenger	S. C. Sneeringer
GUERNSEY	James A. L. Toland	W. L. Denny
LICKING	R. G. Plummer	R. G. Mannino
MORGAN	A. A. Coulson	E. G. Rex
MUSKINGUM	A. C. Ormond	J. H. Bain
NOBLE	E. G. Ditch	N. S. Reed
PERRY		
WASHINGTON	William R. Stewart	Clarence E. Ash
NINTH DISTRICT		
GALLIA	Wm. F. Ashe	Homer B. Thomas
HOCKING	R. C. Jones	O. F. Yaw
JACKSON		
LAWRENCE	George N. Spears	Harry Nenni
MEIGS		
PIKE	A. M. Shrader	M. E. Moore
SCIOTO	O. D. Tatje	George Blume
VINTON		
TENTH DISTRICT		
DELAWARE	A. R. Callander	Mary Kuhn
FAYETTE	M. H. Roszmann	J. H. Persinger
FRANKLIN	William F. Bradley	Joseph M. Gallen
	Helen P. Graves	George P. Hummel
	Warren G. Harding	Robert M. Inglis
	Charles W. Pavey	John E. Martin
	Martin P. Sayers	James H. McCreary
	H. H. Schwarzell	Samuel W. Robinson
	Robert E. S. Young	Anthony Ruppersberg
KNOX	Henry T. Lapp	R. S. Lord
MADISON	J. W. Hurt	Wm. T. Bacon
MORROW	Wm. Lowell Murphy	Stanley Brody
PICKAWAY	Frank Moore	Robert Smith
ROSS	R. W. Holmes	H. M. Crumley
UNION	E. J. Marsh	B. E. Ingmire
ELEVENTH DISTRICT		
ASHLAND	M. D. Shilling	Wayne C. Smith
ERIE	E. J. Meckstroth	W. P. Skirball
HOLMES	N. P. Stauffer	A. J. Earney
HURON	C. J. Cranston	O. J. Nicholson
LORAIN	Theodore Berg	Charles R. Meek
	Leonard Stack	S. D. Nielsen
MEDINA	John Jones	H. T. Pease
RICHLAND	C. O. Butner	R. D. Campbell
	D. W. Dewald	F. M. Wadsworth
WAYNE	A. J. Hartzler	W. R. Schultz

OFFICERS

Pres.	Paul A. Davis	Treas.	R. L. Meiling
Pres.-Elect	Merrill D. Prugh	Past-Pres.	H. M. Clodfelter

COUNCILORS

District		District	
First	D. W. Heusinkveld	Seventh	R. J. Foster
Second	G. A. Woodhouse	Eighth	R. S. Martin
Third	James R. Jarvis	Ninth	C. L. Pitcher
Fourth	Paul F. Orr	Tenth	E. H. Artman
Fifth	Charles L. Hudson	Eleventh	John S. Hattery
Sixth	Carl A. Gustafson		

SCIENTIFIC AND EDUCATIONAL EXHIBITS

The Scientific and Educational Exhibits in the foyer to the Main Ballroom, Mezzanine Floor, Deshler-Hilton Hotel, will be open daily from 9:00 A.M. to 6:00 P.M. on Tuesday, April 13, and Wednesday, April 14; and from 9:00 A.M. to 1:00 P.M. on Thursday, April 15.

GAMMA-RAY PROTECTION ANALYSIS IN DIAGNOSIS

Wm. G. Myers, Ph.D., M.D.; George E. Mueller, Ph.D.; Edwin York, B.S., Ohio State University.

RADIOGRAPHIC MANIFESTATIONS OF SYSTEMIC DISEASES IN THE HANDS

Jack Widrich, M.D., Ohio State University.

CARDIOANGIOGRAPHY

Phillip Smith, M.D.; Charles Wilson, M.D.; J. W. Bull, M.D.; Hugh A. Cregg, M.D., Frederick C. Smith Clinic, Marion.

RADIOGOLD SEEDS IN CANCER THERAPY

Ulrich K. Henscke, M.D., Ph.D.; Arthur G. James, M.D.; William G. Myers, Ph.D., M.D., Ohio State University.

REHABILITATION OF THE SEVERELY HANDICAPPED IN A MEDICAL CARE PROGRAM

Leslie A. Falk, M.D., United Mine Workers of America Welfare and Retirement Fund, Pittsburgh, Pa.

ACTIVE IMMUNIZATION IN POLIOMYELITS

Hart E. Van Riper, M.D., National Foundation for Infantile Paralysis, New York, N.Y.

FEMORAL HEAD REPLACEMENT

Wallace Duncan, M.D.; Robert F. Cooke, M.D.; Fred Holzworth, M.D., St. Luke's Hospital, Cleveland.

THE EXCHANGE TRANSFUSION

The Newborn Service of the Cincinnati General Hospital and Department of Pediatrics, University of Cincinnati.

LEUKEMIA: A TWENTY-TWO YEAR SURVEY OF 1617 CASES

Claude-Starr Wright, M.D.; Charles A. Doan, M.D.; Bruce K. Wiseman, M.D., Ohio State University.

MATERNAL MORTALITY IN FRANKLIN COUNTY, A FIVE YEAR STUDY

Richard L. Meiling, M.D.; Anthony Ruppersberg, Jr., M.D., Columbus Obstetric-Gynecologic Society.

AMBULATION OF HIGH BILATERAL UPPER THIGH AMPUTEES

Veterans Administration Center, Dayton.

TELEOPELVIMETRY

Howard Feigelson, M.D., University of Cincinnati.

SIGMOIDOSCOPY

C. Joseph DeLor, M.D.; F. M. Beman, M.D.; S. W. Robinson, M.D., Department of Gastroenterology, Ohio State University.

GENETIC IMPLICATIONS FOR PLANNED PARENTHOOD

Charles H. Hendricks, M.D., Planned Parenthood League of Ohio.

LIVER FUNCTION TESTS

A. P. Falkenstein, M.D., Alliance City Hospital, Alliance, and Central Clinic and Hospital, Salem.

MODIFIED MYOMA SCREW AND UTERUS HOLDER

Roger B. Scott, M.D., Department of Obstetrics and Gynecology, University Hospitals of Cleveland, Western Reserve University School of Medicine.

THE SYSTEMIC MYCOSES

Samuel Saslaw, M.D., Ph.D., Department of Medicine, Ohio State University.

THE UNIVERSITY OF CINCINNATI BLOOD TRANSFUSION SERVICE PRENATAL PROGRAM

University of Cincinnati Blood Transfusion Service.

ULTRASONICS IN MEDICINE

Herman J. Bearzy, M.D., Department of Physical Medicine and Rehabilitation, Miami Valley Hospital, Dayton.

SKEGGS-LEONARDS ARTIFICIAL KIDNEY

Walter A. Keitzer, M.D., and Manley L. Ford, M.D., City Hospital of Akron.

CLINICAL USE OF PAPER STRIP ELECTROPHORESIS

Robert L. Wall, M.D., Department of Medicine, Ohio State University.

DIAGNOSIS AND TREATMENT OF BIRTHMARKS

Bruce C. Martin, M.D., and J. C. Trabue, M.D., Plastic Surgery Service, Department of Surgery, Ohio State University.

PREVENTION OF RHEUMATIC FEVER

Carl Weihl, M.D.; Louise Rauh, M.D.; Robert Lyon, M.D., Children's Heart Association of Cincinnati, and Pediatric Department, University of Cincinnati.

INTESTINAL OBSTRUCTION IN THE NEWBORN

H. Wm. Clatworthy, Jr., M.D.; William Howard, M.D.; James Lloyd, M.D., The Children's Hospital, Ohio State Medical Center, Columbus.

PAINFUL LESIONS OF SHOULDER GIRDLE

F. H. Mayfield, M.D.; E. S. Lotspeich, M.D.; and C. R. Hunter, M.D., Cincinnati.

SURGERY OF MITRAL STENOSIS

Maurice G. Buckles, M.D., Columbus.

(Continued on next page)

OHIO STATE HEART ASSOCIATION SERVING OHIO THROUGH RESEARCH, EDUCATION, COMMUNITY SERVICES

Ohio State Heart Association, Columbus.

SKEGGS-LEONARDS ARTIFICAL KIDNEY

Jack R. Leonards, Ph. D.; John Davis, M. D.; Robert S. Post, M. D., Western Reserve University School of Medicine, University Hospitals of Cleveland.

FRACTURE OF THE PROMONTORY OF THE CALCANEUS

Arnold D. Piatt, M. D., Newark.

THE PRODUCTION AND INHIBITION OF LACTATION

Ray O. Nulsen, M. D.; Edward Friedman, M. D.; Edward Alberts, M. D.; William B. Carmon, M. D., Jewish Hospital, Cincinnati.

NATURE OF HYPOPHYSIAL AFFECTION IN MENTAL ILLNESS

James W. Papez, M. D., and Mrs. B. Pearl Papez, Assistant, Department of Public Welfare and Columbus State Hospital Laboratory for Biological Research, Division of Mental Hygiene.

DIAGNOSIS AND SURGICAL CORRECTION OF CARDIAC LESIONS

Charles V. Meckstroth, M. D.; Karl P. Klassen, M. D.; Joseph Ryan, M. D., Division of Thoracic Surgery and Division of Cardiology, Ohio State University.

BRONCHOGRAPHY AS AN AID IN THE DIAGNOSIS OF BRONCHOGENIC CARCINOMA

Karl P. Klassen, M. D.; Charles V. Meckstroth, M. D.; Joseph L. Morton, M. D., Ohio State University.

TECHNICAL COMPLICATIONS IN CARDIAC SURGERY—THEIR IMMEDIATE CORRECTION

Henry B. Larzelere, M. D., Toledo.

SUBDURAL HEMATOMA

Robert E. Slemmer, M. D., and Thomas E. Scott, Jr., M. D., Department of Anatomy, University of Cincinnati, and Department of Neurosurgery, St. Mary's Hospital, Cincinnati.

POLYPS OF THE RECTUM AND COLON

R. I. Brashear, M. D., and R. B. Samson, M. D., Columbus.

MANAGEMENT OF INTESTINAL OBSTRUCTION

Edwin H. Ellison, M. D., and Robert Watman, M. D., Department of Surgery, Ohio State University.

BLOOD VOLUME MEASUREMENT IN GASTROINTESTINAL DISEASE

Edwin H. Ellison, M. D., and Clarence I. Britt, M. D., Department of Surgery, Ohio State University.

DIAGNOSIS OF AORTA-ILIAC ARTERY OCCLUSION

Fay A. LeFevre, M. D.; Victor G. de Wolfe, M. D.; A. W. Humphries, M. D.; J. C. Root, M. D., Cleveland Clinic.

INTERVERTEBRAL BODY FUSION AS USED IN LUMBAR DISC THERAPY

B. R. Wiltberger, M. D., Department of Surgery, Section of Orthopaedic Surgery, Ohio State University.

ROLE OF ABNORMAL HEMOGLOBIN IN HEREDITARY HEMOLYTIC DISEASE

John D. Battle, Jr., M. D.; James S. Hewlett, M. D., and Lena Lewis, Ph. D., Cleveland Clinic.

NEOPLASMS OF THE THYROID

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TOXEMIAS OF PREGNANCY TREATED WITH MAGNESIUM SULFATE

J. A. Pritchard, M. D., and A. C. Barnes, M. D., Department of Obstetrics and Gynecology, Western Reserve University School of Medicine.

CLOSED TREATMENT OF FRACTURE

W. S. Smith, M. D.; Leonard Yurko, M. D.; J. L. Morton, M. D., Department of Orthopedics and Department of Radiology, Ohio State University.

THE HEART AND ATHLETICS: A CONTINUATION STUDY

J. W. Wilce, M. D., Department of Medicine, Ohio State University.

TRANSTRACHEAL ARTIFICIAL RESPIRATION

Jay Jacoby, M. D.; William Hamelberg, M. D.; J. P. Reed, M. D., Department of Anesthesiology, Ohio State University.

HEAD AND NECK CANCER

Arthur G. James, M. D., Ohio State University.

DIAGNOSIS AND TREATMENT OF CORONARY ARTERY DISEASE

Henry A. Zimmerman, M. D., St. Vincent Charity Hospital, Cleveland.

COMPLICATIONS OF CORTISONE AND ACTH THERAPY

Martha Southard, M. D., Department of Radiology, Ohio State University.

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U. S. Vitamin Corporation	New York, N. Y.	72
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Woman's Auxiliary Annual Meeting . . .

To Be Held Concurrently with Annual Meeting of Association; Year's Program To Be Planned; Reports Made and New Officers To Be Elected

THE 1954 Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association will be held in the Southern Hotel, Columbus, concurrently with The Annual Meeting of the Ohio State Medical Association. Mrs. N. M. Reiff, Washington Court House, President, announced the following program features:

MONDAY, APRIL 12

9:30 A. M.

Meeting of the Policy Committee, Constitution Committee, and Resolutions Committee.

3:00 P. M.

Pre-Convention Board Meeting.

TUESDAY, APRIL 13

8:30 A. M.

Registration.

9:30 A. M.

Opening Session:

Presiding: Mrs. N. M. Reiff, President.
Pledge of Loyalty.
Address of Welcome: Dr. Judson D. Wilson, President of Columbus Academy of Medicine.
Greetings: Mrs. Harve Clodfelter, President of Woman's Auxiliary to the Columbus Academy of Medicine.
Response: Mrs. Harold Davis, Summit County.
Introduction of Convention Chairmen.
Adoption of Rules of Convention.
Report of Roll Call Chairman: Mrs. J. H. McCreary.
Minutes of the 13th Annual Meeting: Mrs. O. Reed Jones.
Treasurer's Report: Mrs. Karl Ritter.
Report of the Nominating Committee (First Reading): Mrs. O. Reed Jones.
Reading of Necrology.
Report of the Resolutions Committee: Mrs. Edwin H. Artman.
Credits and Awards: Mrs. Harold Messenger.
Elections of Delegates to National Auxiliary Convention.
Recess.

1:30 P. M.

Luncheon: Honoring Past-Presidents of the Woman's Auxiliary to the Ohio State Medical Association, County Presidents.

4:00 P. M.

Tea: Governor's Mansion.

WEDNESDAY, APRIL 14

9:30 A. M.

Second Session:

Report of the Roll Call Chairman.
Report of the Resolutions Committee (Second Reading).
Minutes of the Previous Meeting: Mrs. O. Reed Jones.
Report of the Finance Chairman: Mrs. Paul Woodward.
Panel Discussion: Moderator, Mrs. W. R. Gibson, State Public Relations Chairman. Discussion Leaders: State Chairman.
(1) Civil Defense: Mrs. Craig Wales.
(2) Mental Health: Mrs. W. J. Habeeb.
(3) Legislation. Mrs. Walter Kramer.
(4) Publications: Mrs. V. R. Frederick.
(5) Program: Mrs. C. H. Bell.

(The County President Panelists to be announced later.)

Recess.

12:00 Noon

Luncheon: Honoring Dr. Edward J. McCormick, President of the American Medical Association; Dr. Paul A. Davis, President of the Ohio State Medical Association; Advisory Council, Dr. and Mrs. N. M. Reiff.

Speaker: Dr. Edward J. McCormick.

Program: Mrs. Robert H. Schoene, Franklin County, Chairman.

2:30 P. M.

Schools of Instruction for Presidents, Presidents-Elect and District Directors.

WEDNESDAY EVENING—7.30 P. M.

Annual Banquet, Ohio State Medical Association.

THURSDAY, APRIL 15

Third Session:

Report of the Convention Chairmen.
Report of the Roll Call Chairman.
Minutes of the Previous Meeting.
Unfinished Business.
New Business.
Report of Resolutions Committee (Final Reading).
Report of the Nominating Committee (Final Reading).
Election of Officers.
Mrs. Leo Schaefer, President of the Woman's Auxiliary to the American Medical Association.
Installation of Officers: Mrs. Leo Schaefer.
Inaugural Address: Mrs. A. Paul Hancuff.
Courtesy Resolutions.
Adjournment.

12:00 Noon

Luncheon: Honoring Mrs. Leo Schaefer, Mrs. A. Paul Hancuff and New Officers.

Program: Mrs. Phillip Knies, Franklin County, Chairman.

3:00 P. M.

Post-Convention Board Meeting: Mrs. A. Paul Hancuff, Presiding.

California, Here We Come . . .

Hurry, Get A Reservation on the O.S.M.A. Special Train To A.M.A. Meeting; Grand Itinerary Planned; 100 Have Already Signed Up

ALMOST 100 Ohio physicians and members of their families have signed up for space on the Ohio State Medical Association Special Train to San Francisco next June when the American Medical Association Annual Session will be held in that city.

Better get your reservation request in at once, as space will be assigned on a first-come basis. This all-expense tour offers a chance of a lifetime for you to see many glamorous places throughout the West, with the A. M. A. meeting thrown in as a bargain. Write to Executive Secretary Charles S. Nelson, Columbus Office of the Association, for complete details.

See next page for picture of party's Los Angeles headquarters—Hotel Biltmore—and some of the sights which will be seen in Salt Lake City. →

The Special Train will leave Chicago on June 12, travelling to San Francisco by way of Denver, the Royal Gorge, Salt Lake City, Los Angeles and Yosemite National Park. There will be plenty of sightseeing and fun in Salt Lake City, Los Angeles and Yosemite National Park.

After the A. M. A. meeting in San Francisco, the O. S. M. A. Special will pull out of the Golden Gate City on June 25. En route home, the party will stop at Portland for the famous Columbia River Highway drive, including Multnomah Falls and Bonneville Dam. From there, the train will travel through the very heart of the Northwest Rockies. There will be three days and three nights at grand and glorious Glacier National Park. The trip will end at Chicago on July 3.

The cost of the all-expense trip will be approximately $500 per person, depending on the kind of Pullman space selected and *exclusive* of meals and sightseeing at Los Angeles and San Francisco, hotel in San Francisco, one meal in Portland and round-trip rail and Pullman fare between home city and Chicago. Everything else, even tips, will be included in the all-expense cost.

Mr. Nelson will secure hotel space in San Francisco at either the Drake-Wiltshire or Plaza Hotel for members of the party who want him to do so.

The Pullman Company has promised to provide an all-room, air-conditioned train for the Ohio party. There will be a complete array of diners and lounge and observation cars.

Many who have been on former special train jaunts sponsored by the Ohio State Medical Association have signed up for the 1954 trip, indicating how successful previous trips have been and what a grand time is in store for those who go on the 1954 train. The sightseeing arrangements for the 1954 trip will be even better than those set up for past trips.

Drop a card to the Columbus Office and secure one of the descriptive folders giving complete details about the Special Train. Those who have secured a folder, and are planning to go, should send their application to the Columbus Office at once, so space can be assigned to them and a hotel room in San Francisco reserved for them, if requested.



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Write Your Congressman . . .

Stating Your Views on Move for Compulsory OASI Coverage of Physicians And Jenkins-Keogh Proposal; Arguments on Measures Are Summarized

THE purpose of this article is to focus the attention of Ohio physicians on two proposals which are before the U. S. Congress for action. Obviously, there are many other bills —some of vital importance—pending. They will be discussed in *The Journal* at the appropriate time.

One of the proposals made by President Eisenhower is that some 10 to 11 million self-employed persons, including physicians, should be brought into the Social Security OASI (Old Age and Survivors Insurance) program—compulsory coverage.

The second is a proposal to amend the Internal Revenue Law to allow some tax deferment for self-employed persons (physicians, attorneys, dentists, etc.) participating in voluntary retirement insurance programs. This question is covered by two measures, H. R. 10 and H. R. 11, sponsored by Congressman Thomas Jenkins, Ohio, and Congressman E. J. Keogh, New York. The provisions of these measures may, in the final analysis, be incorporated in a bill to revise the entire internal revenue code. Regardless, the principle behind the measures is the important thing.

Many physicians are opposed to compulsory OASI coverage. On the other hand many physicians are in favor of the Jenkins-Keogh proposals.

BOTH PROPOSALS DISCUSSED

Following are data on both questions. After studying the arguments presented, physicians should make known their opinions to their congressman and Ohio's two U. S. Senators—Senator John W. Bricker and Senator Thomas A. Burke.

Here are excerpts from an editorial which appeared in *The Journal of the American Medical Association*, summarizing definitely but concisely the arguments against compulsory inclusion of physicians in the OASI program and the arguments in favor of the voluntary retirement plan idea.

"An ostensible reason for physicians to disapprove compulsory coverage under OASI warrants only a brief comment. The median age at which self-employed physicians over age 64 are currently retiring is 74. The retirement ages of self-employed lawyers, dentists, and farmers is probably about the same. Under the so-called work rule no eligible person can draw an OASI pension if he earns $75 a month between ages 65 and 75. This would obviously mean that half of the self-employed physicians would, under the President's proposal, be required to pay social security taxes but would not receive one penny of benefits until age 74.

"But relaxing the 'work rule' to make coverage more attractive to these 10 million gainfully employed would, unless accompanied by a sharp increase in OASI taxes, merely increase the get-something-for-next-to-nothing potential of this act. The President's proposal would bring us close to Townsendism, and an elimination of the 'work rule' would just about fulfil the hopes and dreams of Dr. Francis E. Townsend.

"The basic objection to bringing an additional 10 million persons under OASI is that such an action by the Congress would be another long step toward Big Government and the Welfare State. Social security taxes, counting both employers' and employees', are currently only token payments and will defray only a portion of the costs of the OASI pensions. The tax rates of employers and employees could be doubled and also graduated according to age—a change that is much more urgent than a modification of the 'work rule.'

MORTGAGE ON FUTURE GENERATIONS

"The unpaid balance of the pension costs as older persons receive their monthly pension checks must be paid by another generation. Those who oppose this steady march toward the Welfare State must always refuse the bait: in this case, pensions at cut-rate prices. They must oppose the doctrine of individual irresponsibility except for the care of those in dire need, which, in fact, is the essence of the principles that guide the life of a physician in his practice. They must always stand firmly against the exploitation of youth by those who were born many years earlier. They must insist on standing on their own feet and providing for their own retirement needs. Those who can pay should pay their own way; those who cannot pay must, of course, be helped.

VOLUNTARY VS. COMPULSORY

"Opposition to this trend toward the Welfare State is one reason for supporting the Jenkins-(Reed)-Keogh bills (H. R. 10 and 11), which would establish a voluntary retirement plan for the self-employed and the pensionless employed. They would amend the federal internal revenue code but would not change the Social Security Act. They are in the public interest.

"The amount of each person's pension would be determined by how much he set aside for old age, and not one penny would be added to his fund by the government. He would be per-

(Continued on page 282)

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22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Dther Therapy	TYPES DF ULCERS				RELIEF DF SYMPTDMS (Chiefly Pain)				Surgery or Compli-cations[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, D'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

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This may sound trivial—of little importance in a single instance. But, it doesn't take very many single instances to add up to substantial money on additional postage.

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mitted to defer taxes on the annual amount set aside each year until he retired and began to receive his pension, which would be currently taxable.

"The provisions in these bills for tax deferment until retirement are the counterpart of those now enjoyed by employed persons covered by more than 20,000 tax-exempt pension plans. Except in case of permanent disability he could not draw benefits from his fund until age 65, but after age 65 he could draw out benefits as he sees fit.

"These bills, unlike the Social Security Act, would not force one into idle retirement in order to draw on his own pension fund. He could keep right on working as the majority of practicing physicians do."

Florida Cancer Conference

The Third Annual Seminar and Conference and Cancer Cytology will be held at the Cancer Institute at Miami, Fla., April 21-24. The conference will bring together several leading authorities on cancer from this country and abroad. Additional information may be obtained from: Dr. J. Ernest Ayre, director, The Cancer Institute at Miami, 1155 N. W. 14th St., Miami, Fla.

Columbus Lions Club Schedules Series of Medical Programs

A unique arrangement was made by the Columbus Lions Club to have physicians address the organization in a series of medical talks during the February weekly meetings.

Dr. Richard L. Meiling, associate dean of the Ohio State University College of Medicine, spoke on the subject, "The Doctor of Today and Tomorrow."

Dr. Bruce C. Martin, assistant professor and head of the plastic surgery service at the University Health Center, gave an illustrated lecture on recent advances in plastic surgery.

Dr. Ralph E. Worden, director of the Department of Physical Medicine and Rehabilitation at University Health Center, described the work of rehabilitation of patients into productive activity.

Dr. Morris L. Battles, instructor in Ophthalmology at Ohio State, spoke on recent advances in ophthalmology, a subject closely allied with the Lions Club sight-saving program.

Ohio State University recently received a grant of $4,500 from the Damon Runyon Memorial Fund for a research project on urinary adrenocorticosteroids under direction of Dr. Charles A. Doan, dean of the College of Medicine.



How to control itching and scaling for **1** *to* **4** *weeks*

You can expect results like these with SELSUN: complete control in 81 to 87 per cent of all seborrheic dermatitis cases, and in 92 to 95 per cent of common dandruff cases. SELSUN keeps the scalp free of scales for *one to four weeks*—relieves itching and burning after only two or three applications.

Your patients just add SELSUN to their regular hair-washing routine. No messy ointments . . . no bedtime rituals . . . no disagreeable odors. SELSUN leaves the hair and scalp clean and easy to manage.

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Nurses Loans . . .

Project of Woman's Auxiliary to Ohio State Medical Association Is Described in Auxiliary News; Policies Governing Loans Summarized

ONE of the major activities of the Woman's Auxiliary to the Ohio State Medical Association is the Nurses Loan Fund which is available to student nurses and to those graduate nurses who desire to take postgraduate training.

The project was described in an article in the February, 1954, issue of the *Ohio Medical Auxiliary News*, prepared by Mrs. W. H. Evans, 291 Park Ave., Youngstown, chairman of the Nurses Loan Fund.

Mrs. Evans states:

"It is the sincere desire of the officers and members of the Woman's Auxiliary to the Ohio State Medical Association to provide loans to all worthy students, to the limit of the amount of our fund.

"No doubt, there are many students and graduate nurses who find it difficult or impossible to finance their training and it is our sincere desire to help those people. Therefore, a survey of the financial status of the students in your training school and any worthy recent graduate nurse would probably reveal an interested prospect.

"We therefore suggest that anyone interested in obtaining a loan may contact me by letter at the earliest possible time in order that proper arrangements can be made to process the loan."

Following are the policies governing the Nurses Loan Fund as revised in 1954, included in Mrs. Evans' article:

TO WHOM LOANS WILL BE MADE: To those student nurses entering or in training for professional nursing, providing those student nurses have been recommended by the Director of Nurses where the applicants who have applied are in training, or by the Ohio State Nurses' Association.

The Loan Fund is also available to applicants to any school of Practical Nursing which has the approval of the National Association for Practical Nurse Education and of the Medical Association of the County in which the school is located.

Applicants must have acceptable scholastic rating and evidence a sincere desire to make a true contribution to the highest standards of the nursing profession.

RECOMMENDATIONS: Loans for students working to become Registered Nurses will be limited to those entering accredited schools of nursing.

If possible, there shall always be at least one who is enrolled in an accredited school of nursing where she is working to become a Registered Nurse or for a Post-Graduate degree.

Applicants studying for R. N. or Post-Graduate degree shall have preference over other applicants.

APPLICATIONS: Applications to schools of Professional Nursing must be made in writing to the Chairman of the Student Nurses Loan Fund Committee, accompanied by a written recommendation from the Director of Nurses where she is in training, or from the Ohio State Nurses' Association.

Application to schools of Practical Nursing must be made in writing to the Chairman of the Student Nurses Loan Fund Committee, accompanied by a written recommendation from the Co-ordinator or Director of Practical Nursing of the accredited school to which she is applying.

FINANCIAL GUARANTEE: When approved by the Committee, the applicant must furnish her signature and that of a Real Property Owner to a Cognovit Promissory Note made payable to the Woman's Auxiliary to the Ohio State Medical Association, without interest.

Reveal That Rex Morgan, M. D., Is Creation of Toledo Physician

Readers of some 300 newspapers throughout the country have been enjoying the syndicated cartoon strip "Rex Morgan, M. D.," with perhaps little thought to the appended pseudonym "Del Curtis." A recent newspaper article made public the fact that the behind-the-scenes creator of the strip is Dr. Nicholas P. Dallis, Toledo practicing physician and former director of the Toledo Mental Hygiene Clinic.

Another more recent creation of Dr. Dallis (this time "Paul Nicholas") is the cartoon strip "Judge Parker," appearing in about 200 newspapers.

Commenting on the disclosure, *The Cleveland Plain Dealer* had this to say: "The role Dr. Dallis has been allowed to play, through the strips, in exposing medical and legal charlatans and trickery, is the realization of a long cherished dream.

"The American Medical Association has lauded him for his exposure of medical quacks. The Food and Drug Administration has joined the doctors in praising him. And so has the American Cancer Society."

Dr. Dallis writes the continuity for the strip, while Marvin Bradley and Frank Edgington do the artwork.

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in the treatment of a wide range of infections due to gram-positive and gram-negative bacteria, spirochetes, rickettsiae, certain large viruses and protozoa.

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rapid absorption — Within an hour after oral administration in fasting or non-fasting state, effective serum concentrations of Terramycin may be attained.[1] It is widely distributed in body fluids, organs and tissues and diffuses readily through the placental membrane.[2,3]

wide distribution

prompt response — Immediate evidence of Terramycin's efficacy is often obtained by the rapid return of temperature to normal.[4]

excellent toleration — Widely used among patients of all ages, this tested broad-spectrum antibiotic is well tolerated.[5,6]

1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. *53*:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. *74*:261 (June) 1950.
4. Wolman, B., et al.: Brit. M. J. *1*:419 (Feb. 23) 1952.
5. Potterfield, T. G., et al.: J. Philadelphia Gen. Hosp. *2*:6 (Jan.) 1951.
6. King, E. Q., et al.: J.A.M.A. *143*:1 (May 6) 1950.

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Problems of Ohio's Aged . . .

Will Be Discussed at Two-Day Conference on Ohio State University Campus; O. S. M. A. One of Endorsing Organizations; Program Reviewed

INDICATING the widespread interest in problems inherent with the increasing percentage of older persons in Ohio's population, approximately 30 state-wide organizations and agencies have given formal endorsement to the state-wide Conference on Problems of the Aging scheduled to be held on The Ohio State University Campus, Tuesday and Wednesday, March 23-24.

These include the following groups: The Ohio State Medical Association; The Ohio Manufacturers' Association; Altrusa Club of Columbus; The Ohio Hospital Association; The Ohio Council of Retail Merchants; The Ohio Legislative Service Commission; Ohio Library Association; Veterans of Foreign Wars of the U. S.—Department of Ohio; The American Legion, Department of Ohio;

The Ohio State Grange; The Ohio State Nurses Association; Ohio C. I. O. Council; Ohio Rural Health Council; Ohio-West Virginia Area Y. M. C. A.; Ohio Department of Health; Ohio Department of Public Welfare; Ohio Welfare Conference; County Commissioner's Association of Ohio; The Ohio Federation of Women's Clubs; Ohio State Employment Service Division of the Ohio Bureau of Unemployment Compensation;

Ohio Mental Health Association; Ohio State Federation of Labor; Association of Ohio Homes for the Aged; Ohio State Heart Association; Ohio Federation of Business & Professional Women's Clubs; Ohio Recreation Association; Department of Services to Older People of the Council of Social Agencies of Columbus and Franklin County; Community Council for the Aging of the Cincinnati Council of Social Agencies; Ohio Education Association; Ohio Council of Churches.

Joint sponsors of the conference are The Ohio State University and the Ohio Citizens' Council for Health and Welfare. All sessions will be in the Ohio Union building.

FEATURES OF PROGRAM

Dr. Howard L. Bevis, president of the University and General Chairman of the Conference, will speak at the March 23 luncheon session which will open the two-day meeting. Following this session simultaneous Section meetings will be held on the topics, "Jobs-Retirement-Maintaining Income of Older Persons" and "Living Arrangements for Older People." Dr. Theodore G. Klumpp, of New York City, president of Winthrop-Stearns, Inc., and chairman of the President's Commission on the Physically Handicapped, will be the speaker at a dinner meeting concluding the opening day's program. Dr. Klumpp is a member of the National Committee on the Aging.

SECTION MEETINGS

Dr. John D. Porterfield, director of the Ohio Department of Health, will be chairman of a Section meeting on the topic, "Health, Medical Care and Rehabilitation of the Aging," Wednesday morning, March 24. One of the consultants or "resource persons" for this meeting will be Dr. Harry V. Paryzek, of Cleveland, chairman of The Ohio State Medical Association's Committee on Chronic Illness.

Judge Henry J. Robison, Director of the Ohio Department of Public Welfare, will be Chairman of another Wednesday morning Section meeting which will consider the topic "Social Services for the Aging." A third meeting, to be held simultaneously with these two, will be on "Recreation, Leisure Time Activities, and Adult Education for the Aging."

Dr. George T. Harding, of Worthington, president of the Ohio Citizens' Council for Health and Welfare, will preside at the conference's closing luncheon session. Speakers at this session will emphasize the need for marshalling community resources toward meeting the various problems which have highlighted the Section meeting discussions.

Advance registration for the Conference on Problems of the Aging will be handled by the Ohio Citizens' Council offices at 167 East State Street, Columbus. All persons directly or indirectly interested in the topic of the conference are privileged to attend. A registration fee of $2.00 will be charged to help defray the expenses of the conference.

General Physicians Meet In Cincinnati

The Southwestern Ohio Society of General Physicians held a seminar of Cincinnati hospital staffs on February 7 in the Hotel Arms, Cincinnati, in collaboration with medical staffs of local hospitals.

The morning and afternoon program consisted of discussions on six subjects of current interest to general practitioners. The next meeting of the organization will be held on Sunday, March 14, at the Hotel Arms and will be on the subject, "Treatment of Skin Diseases."

FEES FOR CERTAIN PROCEDURES IN MEDICAL SCHEDULE OF VETERANS ADMINISTRATION CHANGED, EFFECTIVE FEB. 1

NEW fees for some of the procedures performed by physicians under the Ohio Home Town Care of Veterans agreement between the Veterans Administration and the Ohio State Medical Association became effective February 1, 1954. Reference to negotiations for changes in the fee schedule were made in the February issue of *The Journal.* Since that issue, most of the suggestions made by the Association for fee schedule changes were approved by the Veterans Administration and the date of February 1 set as the effective date.

Following are the procedures affected. The new fee is listed. The fees for all other items remain as set forth in the V. A. schedule which has been in effect for several years:

VISITS AND EXAMINATIONS

0012—Complete general routine physical examination including routine urinalysis, hemoglobin estimation Tallqvist and withdrawal of blood for Wassermann or Kahn ..... $ 9.00

NOTE: When an examination is done in the home the fee for the home call ($5.00) will be added to that of the examination. This applies to both Items 0011 and 0012.

		Visits within city limits			
		First		Subsequent	
Day*	Office	0013	4.00	0014	3.00
	Home	0015	5.00	0016	4.00
	Hospital	0017	4.50	0018	4.50
Night†	Home	0019	8.00	0020	7.00
	Hospital	0021	8.00	0022	7.00

* Day ..... 8:00 A. M. - 7:00 P. M.
† Night ..... 7:00 P. M. - 8:00 A. M.

AUTOPSY AND BIOPSY

0304—Biopsy with report (4 copies histological technique performed by hospital staff) ..... $ 10.00

0305—Histological technique performed outside V. A. hospital and slides and blocks furnished ..... $ 15.00

GENERAL

9110—Laminagraphy ..... $ 20.00

Surgical Group Offers Program In Cleveland, March 31

The Billroth Surgical Association offers its Spring Postgraduate Assembly in the lecture room of the Cleveland Health Museum, 8917 Euclid Ave., Cleveland, on Wednesday, March 31. The program has been announced as follows:

2:00 - 3:30 p. m.—"Hysterectomy—Total, Subtotal and Vaginal," Dr. Aaron E. Kanter, professor (Rush), University of Illinois; professor and chairman of the Gynecology Section, Cook County Graduate School of Medicine; attending gynecologist to Cook County, Presbyterian and Mount Sinai Hospitals, Chicago.

3:30 - 3:45—p. m.—"Demonstration of Gross Pathology of Ovarian and Uterine Tumors," Dr. Benjamin Kline, director of pathology, The Woman's Hospital, Cleveland.

6:30 p. m.—Banquet, Tudor Arms Hotel, $5.00 a plate.

7:30 p. m.—"Female Endocrinology," Dr. Kanter.

Reservations or applications for membership should be sent to the Secretary, Dr. J. J. Evans, 5504 Superior Ave., (HEnderson 1-4731), or the Treasurer, Dr. Peter Coppedge, 10300 Carnegie Ave., (GArfield 1-3740), before Monday, March 29.

The Billroth Surgical Association has been offering similar spring and fall postgraduate programs since 1950.

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Suggested Remedy:

"Calls By Appointment"-Breon

Breon men call
every 6 weeks, eight
times a year. You
circle the date, fill
in the time, and
plan for regular visits.
No upset schedules.
No office snarl-ups.
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for" calls help you
avoid buying "too
much" of this and "not
enough" of that.
You space your buying
to meet the minimum
requirements for your
individual needs
without overstocking in
one line. The Breon
man in your neighborhood
will be glad to tell
you about "Calls By Ap-
pointment." Just write
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Co., 1450 Broadway,
New York 18, N. Y.

Breon

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

MAKE SURE YOU ARE ELIGIBLE TO VOTE ON MAY 4— THEN BE SURE TO VOTE

ARE you eligible to vote at the important primary elections on next May 4?

If you have not voted during the past two years at a general, special or primary election, you will not be eligible to vote in May unless you register with your county Board of Elections, on or before March 24—forty days prior to the May 4 primaries.

If a member of your family has attained voting age—21 years—since the last election in your city or county and has not registered, he or she must do so on or before March 24 to become eligible to vote in May.

If you are a newcomer to Ohio, you should check with your Board of Elections as to what to do to qualify as a voter in May.

If you have changed your address since the last election in your county, you should go to your Board of Elections and get instructions as to how to qualify for the May 4 elections.

Here are some dates to remember and some additional election data of importance, furnished *The Journal* by Secretary of State Ted W. Brown:

March 5—First day for civilians outside the continental limits of the United States, such as wives of military men, to apply for absent voter ballots.

March 24—Last day for persons who must register in order to qualify for voting, to register with their local Board of Elections.

April 4—First day for absent and disabled voters within the United States to apply for ballots.

April 29—Last day for "absent or disabled" civilians to apply. The deadline is 4 p. m.

May 1—Last day for members of the armed services to apply for ballots. Their deadline is 12 noon. Military service personnel have been eligible to apply for ballots since January 1.

Ohioans who will be more than 10 miles from their polling place and outside their home county on election day are eligible for absent voter ballots.

Civilians must return voted ballots to election boards by noon of April 30 to have them count. Military service personnel have until noon of election day—May 4.

Civilians outside the United States get 60 days, instead of the usual 30 before elections, to apply for absent voter ballots.

Civilians must apply for ballots on forms furnished by election boards. Upon receipt of filled out applications, boards will mail out ballots to be voted and returned in accompanying "identification" envelopes.

Applicants for primary ballots must designate their party affiliation. Otherwise, there is no way to tell whether they should receive ballots listing Democratic or Republican candidates.

Efforts have not been made here to give you all the details. Those should be secured from your election officials.

However, one point should be emphasized: **You should make sure you are qualified to vote on May 4 and you should be sure to vote on that day.**

The primary elections, at which nominees of the parties for important public offices will be selected are most important—more important than many citizens realize. Often the primary contest decides the General Election held in November. Moreover, the poorly qualified candidates can be weeded out at the primaries, leaving the voters better choices at the General Election.

Doctors before they're doctors, are citizens. Good citizens are those who vote at every opportunity. No citizen in these times can afford to let his right to vote go by default. Therefore, better check on yourself immediately as to whether or not you will be eligible to vote on May 4.

HOW SILLY CAN YOU BE, COMMANDER?

Under an Associated Press dateline of February 16 out of Cincinnati, W. J. Owens, commander of an American Legion Post in Cincinnati, is quoted as having inferred that "Communists may have bored into the American Medical Association to promote a shortage of physicians." Owens has written to Congressman Hess of Ohio suggesting a Congressional investigation. He accused the A. M. A. of "screaming socialized medicine at every idea offered to overcome the situation," and stated that "veterans are going to have to fight the A. M. A. to halt the trend toward socialized medicine."

Mr. Owens's statement takes the prize for being one of the silliest and most irresponsible statements yet to be made by certain Legion officials in the war-of-words being waged over a difference of opinion between the A. M. A. and American Legion officials as to certain procedures

and policies of the Veterans Administration program.

Debates on public issues during which honest opinions, based on facts, are expressed will do no one any harm. Ridiculous and false allegations like the statements made by Mr. Owens will—especially the American Legion.

The record will show that the American Medical Association was fighting socialism in various forms before the American Legion was born. Since then, the Legion and the A. M. A. have actively cooperated in fighting socialism and other isms. Simply because the two groups happen to differ now with respect to certain phases of the V. A. program is not a valid reason for either organization to accuse the other of disloyalty or of being a traitor to American principles.

PHYSICIANS AND DENTAL SERVICES

The Columbus Office received a letter recently from a physician asking if he could do dental work in connection with his practice.

The Dental Practice act of Ohio specifies that the provisions of the act do not apply to a legally qualified physician or surgeon **unless he practices dentistry as a specialty.** In the latter instance, the physician would have to qualify under the dental act and secure a license to practice dentistry.

Occasionally, a physician may have to handle dental emergencies. In doing so he would not be violating the law. However, an emergency means "emergency." If a physician should attempt to meet too many dental "emergencies" he would be treading on thin ice and could be called upon to prove that a case is actually an emergency.

Best advice: Unless the life of the patient is at stake, send the patient to a qualified dentist for services.

CANDIDATES SOUGHT FOR RURAL MEDICAL SCHOLARSHIP

The O. S. M. A. Committee on Rural health is now receiving applications for 1954 for the Ohio State Medical Association Rural Medical Scholarship. Now in its sixth year, the scholarship is offered for the purpose of stimulating interest in general practice in rural areas or small towns.

Those eligible to apply are rural or small town young men or women who have been active in youth activities in their communities; have a good scholastic record; possess certain personal characteristics which are considered necessary to make them good physicians; and have been accepted by a medical school any place in the country. Obviously, it is hoped that a scholarship winner will have an intense desire to want to practice in a rural area or small community in Ohio. The scholarship pays $500 each year for four years of medical school.

Members of the Ohio State Medical Association who may know of boys and girls qualified for and deserving of this scholarship should have them write the Columbus Office for details and for an application blank. The time to do so is now, as the selection for 1954 will be made some time in July.

FACTS AND AUTHORS SHOULD BE CHECKED

A letter to the editor of *The Journal of the A. M. A.* points out that the writer is getting a bit fed up with the stories of rascality in the medical profession. He makes no pretense of defending the bad boys. However, he does protest the use of a few isolated instances to try to prove general conclusions and the smearing of a large portion of the medical profession because of the sins of a few.

The following suggestions as to how this problem might be solved are offered by the writer:

"It seems reasonable to suggest that the national medical and hospital societies would do well to ask every publisher of note in this country to refuse to accept for publication any paper adversely critical of the medical care and treatment of patients in our hospitals without first thoroughly investigating the author's integrity and competence and obtaining from competent medical men in active practice absolute proof of the validity of the material that the author submits for publication. Such articles, if they must be circulated nationally, should not generalize as most of them do. They should be specific and should deal with the local situation giving rise to them. Above all they should make clear that the person or institution written about is a specific one and that the criticism does not necessarily apply to other physicians and hospitals."

In our opinion, the ideas offered above are sound. They can be applied in local communities as well as on a national basis. In other words, an understanding as suggested could be attempted in each city or county between the medical profession and publishers. Perhaps the medical profession should take the initiative. Why not have representatives of your County Medical Society discuss the situation with your local editor or editors. Naturally, the medical profession must be willing to do its part in event an understanding and agreement is reached.

IF IT'S DONE, GOOD P. R. WILL FOLLOW

Tangible evidence of how a well-operated emergency medical service or arrangement for providing the services of a physician when people cannot reach their family doctor is found in the following editorial which appeared in the *Cleveland News* after a report of the Committee on

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Each teaspoonful provides:

Sulfacetamide . . . . . 0.166 gm	Sulfamerazine . . . . . 0.166 gm.
Sulfadiazine . . . . . 0.166 gm.	Sodium Citrate . . . . . 0.5 gm.

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Emergency Medical Services of the Cleveland Academy of Medicine had been published:

"There is considerable security in the report of the Academy of Medicine's committee on emergency medical service that nine out of 10 Clevelanders who need emergency service when they cannot obtain their own doctor receive it from another qualified physician within the hour. It is also important, that such standards of service be maintained.

"The committee wisely recommends that the public establish quickly a 'family physician' relationship, and that medical men should name an alternate whom patients can easily reach.

"The task of making house calls remains a primary service to which no doctor can afford to be indifferent. The Academy of Medicine, and the individual doctors should extend themselves, in our judgment to reduce complaints over failure to give service. It is essential public relations for the Academy to assure Cleveland people, and many of them are new residents of this area, that help is available swiftly and conscientiously."

Some kind of an arrangement for meeting this important problem can be worked out in any county, regardless of size, if the local medical society will just act and the physicians will cooperate.

Dr. Vilter Selected To Make Dietary Survey in Egypt

Dr. Richard W. Vilter, of the University of Cincinnati College of Medicine, has been selected by the World Health Organization to survey for the United Nations the causes of anemia and nutritional deficiency diseases in Egypt. He left late in January for a two-months stay.

Dr. Vilter joined the Cincinnati faculty in 1941. Under his direction, the hematologic laboratory at General Hospital has conducted much basic research in metabolic effects of deficiency diseases. He is a member of the Committee on Dietary Allowances of the National Research Council.

Assisting him in the project will be Dr. Helen S. Glazer, of the biochemistry laboratory, University of Cincinnati.

Extension of Cincinnati Stadium To Commemorate Dr. Shank

The contemplated upper-deck enlargement of the University of Cincinnati's James Gamble Nippert Stadium will carry the name of the Reed A. Shank Pavilion, the chairman of Board of Directors announced.

Dr. Shank, a graduate of U. C., member of the University Board of Directors, and ardent supporter of the athletic program, died while attending the November 26 U. C.-Miami football game.

Production Problems Delay Start Of Polio Vaccine Tests

A delay in the manufacture of the trial polio vaccine has postponed to some extent the nationwide validity tests, and Ohio is prepared to modify its original plans to meet these circumstances, according to Dr. John D. Porterfield, director of the Ohio Department of Health.

It has been announced by the National Foundation for Infantile Paralysis that, although the date for start of the trials has been postponed, it is planned to inoculate a sufficient number of children before June to determine scientifically the value of the product.

Dr. Porterfield said that the Ohio Department of Health is prepared to proceed with the trials in certain areas of Ohio provided that the vaccine is available not later than the first week in April. Five weeks are required for the course of inoculations, he said, and another week would be required for observations before the close of the school year.

It is necessary that the trials be completed before the close of the school year for two reasons, Dr. Porterfield asserted. First, it is only through the schools that a close follow-up can be effective, and secondly, to project the trials into the summer season when the polio incidence normally increases would obscure results.

Dr. Porterfield further said that because of the delay it may be necessary to carry out the trials in Ohio on a less extensive scale. He emphasized that he is more interested in a carefully controlled program carried out under exacting conditions than he is in a large scale program. There is no reason, he implied, that the trials cannot be continued next year, provided preliminary experiences indicate their desirability.

The tests are an effort to evaluate the vaccine developed by Dr. Jonas E. Salk, of Pittsburgh. Original plans called for vaccinating between 500,000 and 1,000,000 second-grade children in 200 communities throughout the nation.

Gastroenterological Association To Meet in Milwaukee

A regional meeting of the Central Region (including Ohio) of the National Gastroenterological Association will be held in Milwaukee, Wisc., Sunday, March 28. Scientific Sessions will be held at the Hotel Schroeder beginning at 2:00 p. m., following the semiannual meeting of the Association's National Council.

A copy of the program may be obtained by writing Dr. Joseph Shaiken, 536 W. Wisconsin Ave., Milwaukee 3, or the National Gastroenterological Association, 33 W. 60th St., New York 33.

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Painful Shoulder (including peritendinitis, capsulitis, bursitis, and acute arthritis)

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Licenses Granted . . .

State Medical Board, Acting on the Results of the December 17-19 Examinations, Awards Licenses to 55 Graduates of Medical Schools

AS a result of the December examinations, 55 graduates of Medical Schools were issued licenses to practice medicine and surgery in Ohio, it was announced following a meeting of the State Medical Board on January 26.

In addition, 21 graduates of osteopathic schools were authorized licenses to practice osteopathic medicine and surgery in the State. In the limited practice field, certificates were authorized for two chiropodists, five mechanotherapists, four chiropractors, ten masseurs and one cosmetic therapist.

Highest grades in the medical examinations were made by Frederick H. Wentworth, Columbus, a graduate of Cornell University Medical College, with 89 per cent.

Second highest grade went to M. Kenneth Kaufmann, Cleveland, a graduate of the University of Illinois College of Medicine, with 87.9 per cent, and third to Mary D. Brown, Cincinnati, Medical College of Virginia, whose average was 87.8 per cent.

Following is the list of those licensed to practice medicine and surgery:

Harolds G. Alksnis, Utica, N. Y., University of Latvia; John W. Barnes, Dayton, Northwestern University; Hugo Berzins, Louisville, Ky., University of Latvia; Raymond S. Boniface, Pittsburgh, Pa., University of Budapest; Mary D. Brown, Cincinnati, Medical College of Virginia; John E. Burke, Youngstown, Temple University;

Denis V. Campbell, Cleveland, Marquette University; Nicholas Chylak, West Orange, N. J., University of Lemberg; William E. Daehler, Cincinnati, University of Michigan; Paul A. Dosch, Columbus, Stritch School of Medicine, Loyola University; Louis V. Dorogi, St. Louis, Mo., University of Debrecen; Isidor Dubicki, Lima, University of Poznan;

Stanley A. Earley, Jr., Dayton, University of Zurich; Arnold Eicens, Brooklyn, N. Y., University of Zurich; Arnold Eicens, Brooklyn, N. Y., University of Latvia; Gabriel P. Escobar, Garfield Heights, National University of Colombia; Banjamin Farah, Cleveland, University of Paris; Alex S. Farkas, Cleveland, University of Budapest; Elias Freeman, Long Island, N. Y., University of Warsaw;

Elis P. George, Astoria, N. Y., University of Athens; Evangelos A. Georgoulis, Cleveland, University of Chicago; Stefan J. Harasymowicz, Cleveland, University of Edinburgh; Richard M. Iammarino, Cleveland, Loyola University;

Lloyd E. Johnson, Cleveland, University of Wisconsin; Aleksandrs Kakis, Western State, Tenn., University of Latvia; Vincas Kanauka, Brooklyn, N. Y., University of Kaunas; Ilona L. Kasa, Cleveland, University of Debrecen; Marion K. Kaufmann, Cleveland, University of Illinois; Peter J. Kazlauskas, Cambridge, University of Kaunas; Vincent Kozica, Chicago, University of Kaunas;

Mircea I. Lengyel, Canton, Loyola University; Witold Lewicki, Gloversville, N. Y., University of Warsaw; Elza Madernieks, Cleveland, University of Latvia; Lawrence L. Maggiano, Youngstown, Loyola University; Eugene J. Martos, Toledo, University of Pecs; Oliver A. McKee, St. Louis, Mo., Royal College of Dublin; Francis Meszaros, Cleveland, University of Budapest;

Donald R. Pinkerton, Akron, Temple University; Cho Tak Poon, Toledo, St. Louis University; Leonards Primanis, Columbus, University of Latvia; Ira Ramins, Mentor, University of Latvia;

Zigmas Sabataitis, Chicago, University of Kaunas; Jonas Sandargas, Cleveland, University of Kaunas; Keith Wade Sehnert, Detroit, Mich., Western Reserve University; Alfreds Smits, Beckley, W. Va., University of Latvia; John F. Sundermeyer, Toledo, Marquette University; Laszlo Szentendrey, Cleveland, University of Budapest;

Charles E. Taylor, Springfield, Northwestern University; Edward Tennenbaum, New York, N. Y., University of Lwow; James L. Tsomides, Cleveland, George Washington University; Jaroslav K. Turkalo, New York, N. Y., Catholic University of Louvain; Michael Varga-Sinka, Portsmouth, Va., University of Szeged;

Horst D. Weinberg, Cincinnati, University of Chicago; Frederick H. Wentworth, Columbus, Cornell University; William S. White, Drexel Hill, Pa., University of Toronto; Maria B. Widuch, Wheeling, W. Va., University of Stefan Batory.

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states. Intended city of residence stated in application, and medical school of graduation are given.

December 18—Charles W. Humphreys, Jr., Euclid, University of Maryland; Irving L. Shonberg, Youngstown, Chicago Medical School.

January 26—Hugh J. Bonner, Cincinnati, McGill University; John C. Buckingham, Northwestern University; James W. Calvert, Ports-

mouth, Indiana University; Robert E. Campbell, Cleveland, University of Colorado; Vincent S. DiGiulio, Warren, University of Illinois;

Virginia S. Edwards, Mansfield, University of Illinois; Charles O. Hamilton, Springfield, Indiana University; Charles Jobson, West London Hospital Med. School; Charles W. Landis, Columbus, Indiana University; Richard M. Lott, Massillon, University of Rochester;

Howard C. MacMillan, Wooster, Columbia University; Daniel C. Maras, Cleveland, Hahnemann Med. College; William Molnar, University of Budapest; Marie L. Porter, Youngstown, Meharry Med. College; Norman F. Stambaugh, Jr., Dayton, Emory University;

Harry D. Tripp, Columbus, Northwestern University; Joseph Zabner, University of Warsaw.

Finds Physician Distribution in United States Good

A seven-year study has disclosed that the distribution of physicians in the United States in relation to the people they serve is extraordinarily good.

The first of its kind, the study was conducted by Frank G. Dickinson, Ph. D., Chicago, director of the American Medical Association's Bureau of Medical Economic Research. Dr. Dickinson, who used 1950, a population census year, as the basis for the study, made his report at the 50th annual Congress on Medical Education and Licensure in Chicago.

To make this study, Dr. Dickinson divided the country into 757 areas, using the trading area principle which is based on road systems and marketing habits of the people, not on state, county and city boundaries.

In the 757 areas, Dr. Dickinson found there were 15,192 towns, villages and cities with one or more physicians; 5,311 of these towns, villages and cities were served by one active practicing physician. The number of persons in each area per active practitioner varied from 5,100 in the area around Monticello, Utah, to 380 in the Rochester, Minn., area.

Dr. Dickinson included in the category of active private practitioners only those physicians engaged in general practice or part-time or full-time specialization. Not included in the category were those physicians in the government or armed services, interns and residents, those retired or not in practice, and those in industry, teaching, research or administrative work.

Seventy-five of the 757 areas had more than 2,000 persons per active physician. However, Dr. Dickinson explained, these areas were among the most sparsely populated ones in the nation, located in the mountain, west-north-central, and east-south-central regions of the country. The addition or redistribution of only 361 physicians into these areas would have alleviated this condition, he added.

Dr. Dickinson pointed out that while one-sixth of the land area of the United States was outside a 25-mile radius of the closest town with a physician in active private practice, only one-sixth of one per cent of the nation's population lived in this territory. With today's transportation, the physician is able to reach more patients in less time than his predecessor. A patient who is 30 miles away from his doctor today is actually closer in terms of time than most patients four miles away 50 years ago.

According to the report, in 1950 every city, town or village with more than 5,000 population had at least one physician in active private practice, as had 96 per cent of those with a population between 2,500 and 5,000, 88.3 per cent of those with a population between 1,000 and 2,500, and 21 per cent of those with a population between 100 and 1,000. More than half of the latter group had less than 250 inhabitants, it was added.

Dr. Dickinson's report stated that the recent, rapid rate of medical progress has been aided by better food, housing, sanitation, etc. It was Dr. Dickinson's opinion that, from the standpoint of public welfare, the greatest current shortages of highly trained personnel occur in the fields of physics, chemistry and teaching.

The survey touched on the subject of physicians in the armed services during World War II. At that time, 40 per cent of the country's physicians were in the armed services, leaving 60 per cent to care for the 91 per cent of the population who remained civilian. During this time, civilians economized on the use of civilian physicians, he stated, and most indices of health indicated improvement during the national emergency—a situation which would probably repeat itself in any future national emergencies, he added.

The report is entitled "The Distribution of Physicians by Medical Service Areas."

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In Memoriam . . .

George Theron Blydenburgh, M. D., Delaware; Cornell University Medical College, 1918; aged 63; died January 22; member of the Ohio State Medical Association and the American Medical Association; active on numerous committees of the Delaware County Medical Society and a delegate to the State Association for several terms. Dr. Blydenburgh went to Delaware in 1933 after a varied medical career, including service in the Navy and 10 years as a medical missionary in China. He was director of the student health center of the Ohio Wesleyan University and served as deputy commissioner in the district health department. Active in health organization work, he served three years as secretary-treasurer of the American College Health Association. Memberships included those in Phi Beta Kappa, the American Public Health Association and the American and Ohio Student Health Associations, and the Methodist Church. Surviving are his widow; two sons, one of whom is Dr. George D. Blydenburgh, also of Delaware; a daughter, a brother and three sisters.

Joseph A. Bodnar, M. D., Cleveland; Western Reserve University School of Medicine, 1926; aged 58; died January 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Bodnar had been a practicing physician in Cleveland for about 25 years. Activities included memberships in the Catholic Church and the Knights of Columbus. He is survived by his widow and two sons.

Maynard O. Brown, M. D., Cincinnati; Ohio State University College of Medicine, 1929; aged 58; died January 14; member of the Ohio State Medical Association. A practicing physician in Cincinnati for many years, Dr. Brown was operator of the Brown Diagnostic Laboratory. Survivors include his widow, two daughters, his mother and a brother, Dr. Anson L. Brown of Columbus.

Deane D. Davis, M. D., Grove City; Starling Medical College, Columbus, 1901; aged 75; died January 8; member of the Ohio State Medical Association; member of the American Medical Association. A recipient of the Ohio State Medical Association's 50-Year Pin and Certificate, Dr. Davis had practiced the past 30 years in Grove City. A veteran of the Spanish-American War, he was active in the Lions Club, the Masonic Lodge and the Lutheran Church. Surviving are his widow and a daughter.

Edward James Duffy, M. D., Dayton; St. Louis University School of Medicine, 1925; aged 55; died January 16; member of the Ohio State Medical Association. Dr. Duffy had been engaged in the practice of medicine in Dayton since the completion of his medical education. Affiliations included memberships in the The Catholic Church, the Holy Name Society, and the Fraternal Order of Eagles. He is survived by his widow, a daughter, two sons, two brothers and four sisters.

Stacey Flournoy, M. D., Cleveland; University of Tennessee College of Medicine, 1906; aged 74; died January 6. Dr. Flournoy moved to Cleveland in 1927. He was a member of the Elks Lodge and the American Woodmen.

C. Lee Graber, M. D., Lakewood; Medical College of Ohio, Cincinnati, 1898; aged 79; died January 23; member the Ohio State Medical Association; American Medical Association; American College of Surgeons and the Radiological Society of America. Dr. Graber was a recipient of the 50-Year Pin of the Ohio State Medical Association, having practiced some six years in Mount Eaton before he moved to Cleveland. Founder of Lakewood Hospital, he was chief of staff there from 1907 until 1933 and chief of surgery until 1948. In addition to his professional work, he was active in many community groups, including the Methodist Church of which he was a trustee, the Shrine and the Westwood Country Club. His widow and two brothers survive.

Chauncy O. Hudson, M. D., Painesville; Cleveland Medical College, Homeopathic, 1897; aged 79; died January 19; member of the Ohio State Medical Association through 1946; former vice-president of the Lake County Medical Society. Dr. Hudson began his practice in Chardon and after six years there moved to Painesville where he had practiced since. He had received the 50-Year Pin of the Ohio State Medical Association. A man of numerous avocations, Dr. Hudson was a 32nd Degree Mason and was active in several Masonic bodies. Surviving are his widow, two daughters, two sisters and a brother.

George H. Kress, M. D., Los Angeles, Calif.; Medical College of Ohio, Cincinnati, 1899; aged 79; died January 18; member of the California Medical Association. A native Cincinnatian, Dr. Kress moved to California early in his career. From 1914 to 1938, he served as dean of the Los Angeles Medical Department of the University of California Medical School.

Wallace Roy McClellan, M. D., Akron; Jefferson Medical College of Philadelphia, 1912; aged 66; died January 15. Dr. McClellan was examining physician for the Goodyear Tire & Rubber Co.

Theodore R. Marvin, M. D., formerly of Akron and Elyria; Ohio State University College of Medicine, 1943; aged 37; died early in Janu-

ary in a traffic accident while serving with the Medical Corps of the Air Force in Japan. Dr. Marvin, after his discharge from the Navy following World War II, practiced in Akron, and later in Pell City, Ala. Recalled to service, he went to Japan about six months ago. He is survived by his widow and a son, who are residing in Sarasota, Fla.

John A. Mercer, M. D., Greenfield; Kentucky School of Medicine, Louisville, 1888; aged 87; died January 20. Dr. Mercer moved from New Vienna to Greenfield in 1915 and practiced there until his retirement in 1946. He was a member of the Masonic Lodge, the Knights of Pythias and the Odd Fellows.

Frank A. Oakley, M. D., Cleveland Heights; Medical Faculty of Trinity University, Toronto, Canada, 1897; aged 84; died January 17; former member of the Ohio State Medical Association, last in 1935; member of the American Urological Association; member of the American College of Surgeons; president of the Academy of Medicine of Cleveland, 1919. Dr. Oakley practiced for about 40 years in Cleveland before his retirement in 1940. He was a member of the Masonic Lodge and the Knights of Pythias. Surviving are his widow and a daughter.

Robert Eugene Ralston, M. D., Lakewood; Ohio State University College of Medicine, 1947; aged 30; died January 17; member of the Ohio State Medical Association. After being released from active duty with the Navy, in 1952, Dr. Ralston went to Springfield and later moved to Cleveland. Surviving are his widow, two children, his father, grandfather, stepmother and two sisters.

Otto W. Schwarz, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1913; aged 63; died January 4. Dr. Schwarz practiced for approximately 40 years in Cincinnati. Surviving are a son, two daughters and two sisters.

Nicholas J. Seybold, M. D., Toledo; Toledo Medical College, 1913; aged 63; died January 21; member of the Ohio State Medical Association and the American Medical Association; fellow of the American College of Physical Therapy. A practicing physician in Toledo for 35 years, Dr. Seybold was for many years head of the Physiotherapy Department at St. Vincent's Hospital. He was a veteran of World War I, having served in the Medical Corps. Affiliations included memberships in the American Legion, the Holy Name Society, Toledo Yacht Club, Toledo Zoological Society, Knights of Columbus, North Toledo Business Association, and the Varsity T Club. Surviving are his widow, a daughter and a son.

John P. Sharp, M. D., Akron; Hahnemann Medical College of Philadelphia, 1915; aged 60; died January 19; former member of the Ohio State Medical Association, last in 1947. Dr. Sharp moved from Youngstown several years ago to Akron where he was associated with the Veterans Administration. He is survived by his widow and a son.

James Hubert West, M. D., Tucson, Arizona; Western Reserve University School of Medicine, 1915; aged 66; died January 8; former member of the Ohio State Medical Association, last in 1947; diplomate of the American Board of Radiology; member of the Radiological Society of North America and the American College of Radiology. Dr. West served in the Medical Corps of the Ohio National Guard at Fort Bliss early during World War I. In 1923 he returned to Cleveland and became associated in practice with Dr. John D. Osmond, Sr. He moved to Arizona in 1947. Immediate survivors include his widow, a sister and a brother.

Richard Maskrey Wilson, M. D., Martins Ferry; University of Pennsylvania School of Medicine, 1930; aged 48; died January 21; member of the Ohio State Medical Association and the American Medical Association. Upon completion of his internship, Dr. Wilson returned to his native Martins Ferry where he was associated in practice with his father, Dr. Richard H. Wilson. In addition to his professional work, he was active in several community organizations including the Masonic Lodge, the Elks Lodge and the Presbyterian Church. Surviving in addition to his father, are his step-mother and a son.

Roland C. Young, M. D., Toledo; Rush Medical College, University of Chicago, 1921; aged 57; died January 7; member of the Ohio State Medical Association and the American Medical Association. Former delegate of the Toledo Academy to the State Association and active on numerous Society committees. Dr. Young had been a practicing physician since 1922 in Toledo where he was a staff member of the Flower, Maumee Valley, Toledo, Mercy and Riverside Hospitals and a consultant at Toledo State Hospital. He was president of the board of trustees of the local Y. M. C. A. Survivors include his widow, two daughters, a son and a sister.

1953 Sets Another All-Time High In Number of Babies Born

The greatest baby boom in United States history continued unchecked through 1953, with the total of babies born during the year establishing a new, all-time high of more than 3,950,000, Metropolitan Life Insurance Company statisticians report.

It was the seventh year in succession in which the number of births exceeded 3,500,000. The year's total was about two per cent higher than for the preceding year, and more than 50 per cent higher than in 1940. The 1953 birth rate was approximately 25 per 1,000 population.

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"... reports on its use in patients with pneumococcal pneumonia, surgical infections, or urinary tract infections indicate that the oral administration of tetracycline is followed by rapid clinical response. **Symptoms, including fever, largely cleared up within 24 to 48 hours."**[1]

1. English, A. R.; P'an, S. Y.; McBride, T. J.; Gardocki, J. F.; Van Halsema, G., and Wright, W. A.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.
2. Finland, M.: Brit. M. J. 2:4846 (Nov. 21) 1953.

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Tri-State Medical Association To Give Program in Toledo, April 1

The Northern Tri-State Medical Association, composed of physicians of the adjoining areas of Ohio, Indiana and Michigan, will hold its 81st annual meeting on Thursday, April 1, at the headquarters of the Academy of Medicine of Toledo, 3101 Collingwood Ave., Toledo.

The program is as follows:

8:30- 9:30 a. m.—Registration and coffee and doughnut hour for physicians and wives, served by Woman's Auxiliary.

9:30- 9:45—Address of welcome by Dr. Bernhard Steinberg, president of the organization, and Dr. Frank Rawling, president, Toledo Academy.

9:45-10:45—"Allergic Diseases." Coordinator, Dr. John Sheldon, professor of medicine, University of Michigan. Panel: Dr. Karl Figley, past-president, American Academy of Allergy, Toledo; Dr. Frank Rawling, president, Toledo Academy of Medicine.

10:45-11:15—"Problems of Office Practice in Internal Medicine." Dr. William Gordon, attending physician, Harper Hospital, Detroit; Interrogator, Dr. John L. Stifel, Chief of Staff, Toledo Hospital.

11:15 - 12:15 — " Clinicopathological Conference. " Differential Diagnosis by Dr. Gordon M. Todd, member of staff, Toledo Hospital and St. Vincent's Hospital. Pathological Changes and Correlations by Dr. Plinn F. Morse, pathologist, Harper Hospital, Detroit. Summation by Dr. William Gordon.

12:30- 1:15 p. m.—Luncheon.

1:15- 1:45—"The Anatomy of Humor" by Mr. Allen Saunders, prominent cartoonist.

1:45- 2:00—Business meeting and election of officers.

2:00- 3:00—"Problems in Endocrinology." Coordinator, Dr. Thomas Frawley. Panel: Dr. Burton L. Baker, professor of anatomy, University of Michigan; Dr. E. Perry McCullagh, endocrinologist, Cleveland Clinic; Dr. Albert H. Holland, medical director, Armour Laboratories, Chicago.

3:00- 4:00—"Gastrointestinal Diseases." Coordinator, Dr. George B. Eusterman, formerly of Mayo Clinic, now medical director Sinai Hospital, Detroit. Panel: Dr. John G. Mateer, physician-in-chief, and Dr. Laurence S. Fallis, surgeon-in-chief, Henry Ford Hospital, Detroit.

4:00- 5:00—"Urological Diseases." Coordinator, Dr. Reed M. Nesbit, professor of urology, University of Michigan. Panel: Dr. Carroll Hyde, urologist, South Bend Clinic, South Bend, Ind.; Dr. A. S. Avery, member of active staffs, Mercy and St. Vincent's Hospitals, Toledo, and past-president, Detroit Urological Society.

Physicians and their wives are invited. It is suggested that those who plan to attend arrange to be in Toledo for the special color television program on cancer at the Toledo Academy headquarters, between 5 and 6 p. m. on Wednesday, March 31. The subject of the telecast is, "Advances in Control of Cancer of the Colon and Rectum." Registration for physicians at the Academy from 1:00 p. m. to 5:00 p. m. and for their wives at the Commodore Perry and Hillcrest Hotels.

New Members of O. S. M. A.

The following are the names of new members of the Ohio State Medical Association since January 5, 1954. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ADAMS COUNTY
Herman P. Hyder, West Union

ALLEN COUNTY
Chandler D. Gibbs, Lima
Clemente E. Kelley, Jr., Lima

ASHTABULA COUNTY
Gordon K. Jones, Ashtabula
Harmon O. Tidd, Ashtabula

ATHENS COUNTY
Arthur L. Dobosiewicz, Nelsonville

BELMONT COUNTY
Gerard H. DeGenova, Bridgeport
Murry B. Hunter, Bellaire
Charlotte C. Levine, Bellaire
Milton D. Levine, Bellaire
James F. Sutherland, Martins Ferry

BUTLER COUNTY
Robert M. Kappers, Hamilton

CLARK COUNTY
Edward L. Ringer, Springfield

CUYAHOGA COUNTY
Lois J. Carter, Cleveland
Paul H. George, Cleveland
Lambert J. Hucin, Cleveland
Clarence R. Laing, Cleveland

FULTON COUNTY
James E. Boyd, Wauseon

GREENE COUNTY
Claude S. Hambrick, Xenia

HAMILTON COUNTY
Norman H. Blatt, Cincinnati
John Wm. Durkin, Jr., Cincinnati
Robert T. Gallagher, Cincinnati
Melvin Gillett, Newport, Kentucky
Irvin S. Silverstein, Cincinnati
Jakob Wacker, Cincinnati

HANCOCK COUNTY
Ernest W. Johnson, Findlay

HENRY COUNTY
Robert J. Blough, Deshler

KNOX COUNTY
James V. Kennedy, Utica
David T. Whitcomb, Centerburg

LORAIN COUNTY
William W. Carroll, Wellington

MAHONING COUNTY
James R. Gillis, Youngstown

MARION COUNTY
Albert D. Kapcar, Marion
Douglas J. Thompson, Marion
Frank C. Vogt, Marion
Robert E. Weimer, Marion
Ransom R. Williams, Marion
Charles W. Wilson, Marion

MONTGOMERY COUNTY
Philip Andrews, Dayton
Roscoe C. Brand, Jr., Dayton
Clifford E. Gebhart, Miamisburg
A. Ward McCally, Jr., Dayton
Carl W. Noble, Dayton
James A. Rodeghero, Dayton
Donald B. Rogers, Dayton
Rodger L. M. Taylor, Dayton

PICKAWAY COUNTY
Henry H. Swope, Jr., Circleville

RICHLAND COUNTY
Charles V. Adair, Mansfield
Harold N. Johantgen, Shelby

SHELBY COUNTY
Thomas W. Hunter, Sidney
Thomas C. Rockwell, Botkins

STARK COUNTY
David T. Fitzelle, Alliance
Melvin W. Harris, Canton
Walter T. Kasserman, Canton
Frank J. Schirack, Canton
Ernest R. Valentine, Alliance

TRUMBULL COUNTY
A. A. Guiducci, Warren

VAN WERT COUNTY
Edwin Wm. Burnes, Van Wert
Jack H. Cox, Van Wert

WAYNE COUNTY
J. H. Gruter, Wooster

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Pediatric Program Scheduled In Cincinnati

A day's program of pediatric subjects has been arranged by the Pediatric Department of The Cincinnati Medical College for Thursday, March 25, 1954. The following notice has been sent to the medical societies of southwestern Ohio but physicians from other parts of the state are welcome.

PROGRAM

9:00 a. m.—"Poliomyelitis Problems"—Dr. John E. Allen.

10:00 a. m.—"Erythroblastosis and Exchange Transfusions"—Dr. Carl A. Koch; Dr. Frank W. Kellogg.

11:00 a. m.—"Patient Presentations"—Dr. Harry C. Shirkey and Dr. Carl Weihl.

12:00 Noon—Luncheon—Vernon Manor Hotel.

2:00 p. m.—"Measles: Prevention, Complications, and Treatment"—Dr. John E. Allen.

2:45 p. m.—"Respiratory Infections in Childhood: Differentiation and Treatment"—Dr. Harry C. Shirkey.

3:30 p. m.—"Control of Rheumatic Fever"—Dr. Louise W. Rauh.

4:45 p. m.—Rounds at Children's Hospital.

The symposium will be held on the Pediatric Pavilion (H Pavilion) of the Cincinnati General Hospital. The presentations will be preeminently practical, with adequate time allowed for questions, and a brief intermission between presentations.

Registration will be limited to 25 physicians; a fee of $5 will include the cost of luncheon. Reservations, accompanied by a check for $5, may be addressed to: Dr. Frank Kellogg, Treasurer, Department of Pediatrics, Cincinnati General Hospital, Burnet Avenue, Cincinnati 29, Ohio.

University of Cincinnati Announces Symposium on Fluorides

The Institute of Industrial Health of the University of Cincinnati announces a Symposium on Fluorides to be presented by the Kettering Laboratory in the Department of Preventive Medicine and Industrial Health.

The meetings will take place on May 10, 11, and 12, 1954, and will be conducted by staff members of the Kettering Laboratory and a number of guest lecturers whose work in the field is contemporary.

The course will be open to physicians in industry and public health and to other professional persons who are interested in the problems of fluorides.

Persons interested in attending should write: Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio. A registration fee will be charged.



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Second Nutrition Conference To Be Held at Ohio State

The Second Conference on Human Nutrition will be held March 31-April 1 in the Ohio Union, Ohio State University campus, Columbus. The conference is under joint sponsorship of the Ohio Nutrition Committee, the Ohio Department of Health, the Institute of Nutrition and Food Technology of Ohio State University, and the Society of Sigma Xi.

Reservation for dinner ($3.00) and luncheon ($1.65) should be sent with check before March 26 to Professor Walter L. Slatter, Room 112B, Agricultural Laboratories Bldg., Ohio State University, Columbus, Ohio.

The program has been arranged as follows:

Wednesday afternoon, March 31:

"Soil, Climate, and Nutritional Value of Food," Dr. L. M. Turk, Agricultural Experiment Station, Michigan State College.

"The Effect of Current Processing Methods on the Nutritive Value of Foods," by Roy E. Morse, director of research, Wm. J. Stange Co., Chicago.

"Motivation Factors in Changing Food Habits," Dr. Harold B. Pepinsky, Department of Psychology, Ohio State University.

Dinner—6:00 P. M.—Ohio Union.

Wednesday evening, March 31, 8:00 P. M.:

"Recent Developments in Human Nutrition," Dr. Norman Jolliffe, director, Bureau of Nutrition, New York City.

Thursday morning, April 1:

"Nutrition and Growth in Young Children," Dr. Thomas E. Shaffer, Department of Pediatrics, College of Medicine, Ohio State University.

"Symposium on Nutrition in Surgery," Dr. Robert Zollinger and Staff, Department of Surgery, College of Medicine, Ohio State University.

Luncheon—12:00—Ohio Union.

Thursday afternoon, April 1:

"Iodine Deficiency, A Public Health Problem," Dr. John D. Porterfield, director, Ohio Department of Health.

"The Fluoridization Problem in Ohio," Hamilton B. G. Robinson, associate dean, College of Dentistry, Ohio State University.

International Polio Conference To Be Held in Rome

The Third International Poliomyelitis Conference, sponsored by the International Poliomyelitis Congress, will be held at the University of Rome, Italy, September 6-10.

Those who plan to attend should make arrangements by June 15 with: Secretariate, Third International Poliomyelitis Conference, Via Lucullo 6, Rome, Italy.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

HAMILTON

Five physicians were honored at the December meeting of the Academy of Medicine of Cincinnati for a half century of service in the medical profession. Present to receive the 50-Year Pin and Certificate of the Ohio State Medical Association were Dr. Charles Goosman, Dr. Charles E. Hauser, Dr. Leo I. Nelson and Dr. L. A. Nicholas. Not able to be present because of an injury was Dr. Mildred J. Bode. Making the presentation was Dr. David W. Heusinkveld, Cincinnati, First District Councilor.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

GREENE

Speakers for the January 14 meeting of the Greene County Medical Society were Dr. H. R. Tharp, Xenia, and Dr. Dayton Clark, Dayton. The subject under discussion was "Cancer."

MIAMI

Dr. Eric O. Ogden, Department of Physiology, Ohio State University, was guest of the Miami County Medical Society on February 5.

A panel discussion was held for the public at Troy High School Auditorium, before about one hundred people. The panel was composed of Dr. Ogden, Dr. Hugh Wellmeier and Dr. John Quirk of Piqua, and Dr. M. C. Kiser, Tipp City. Dr. Harry Shilling, Troy, acted as moderator.

Dr. Ogden spoke before the Miami County Medical Society at the afternoon meeting on the research projects that are being carried on at Ohio State Medical College regarding the heart and associated problems, emphasizing the sodium retention and water balance. Dinner was held at the Detter Hospital.

MONTGOMERY

Two physicians were presented engraved plaques at the January 8 meeting of the Montgomery County Medical Society in Dayton, for "outstanding service to the community and to medicine." They are Dr. Merrill D. Prugh, President-Elect of the Ohio State Medical Association; and Dr. Robert E. Zipf, Montgomery County coroner.

Presentation was made by Dr. William H. Hanning, 1953 chairman of the society's public relations committee which sponsored the awards.

Installation ceremonies for the following officers constituted a feature of the meeting: Dr. Richard C. Miller, president; Dr. T. L. Light, president-elect; Dr. Eldrin W. Smith, vice-president; Dr. Joseph M. Wilson, secretary; Dr. James M. Shaffer, treasurer; and Dr. Thomas A. Weaver, trustee.

A joint meeting with the staff of St. Elizabeth Hospital was held on February 5 in the hospital auditorium. Speaker was Dr. Arthur M. Master, assistant clinical professor of medicine, College of Physicians and Surgeons, New York, who discussed "Chest Pain—Qualities Characteristic of Coronary Versus Non-Cardiac Disease."

PREBLE

Dr. Elmer A. Curry, of Eaton, was honored at the February 4 meeting of the Preble County Medical Society, for his half-century of service in the medical profession, although he was unable to be present at the meeting. The 50-Year Pin and Certificate of the Ohio State Medical Association was conveyed by Dr. George A. Woodhouse, Pleasant Hill, Second District Councilor, and presented to Dr. Curry at the Reid Memorial Hospital, Richmond, Ind.

Dr. Curry practiced for a number of years in Cincinnati and returned to his native Gettysburg upon retirement. He has been living in Eaton recently. He celebrated his 91st birthday last June.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, spoke on the subject, "The More Successful Approach to the Treatment of the Leukemias," at the January 15 meeting of the Lima and Allen County Academy of Medicine.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

Eight physicians were honored at the January 19 meeting of the Academy of Medicine of Toledo

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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), Lancet *2*:1002 (Dec. 1) 1951.
2. Wilkins, R.W.: Combination of Drugs in the Treatment of Essential Hypertension, Mississippi Doctor *30*:359 (Apr.) 1953.

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when they were presented the 50-Year Pin and Certificate of the Ohio State Medical Association. They are: Dr. L. H. Hauman, Dr. Clarence A. Berger, Dr. Nathan W. Brown, Dr. Thomas M. Crinnion, Dr. Wallace H. Tracy, Dr. L. A. Willoughby, Dr. John F. Wright and Dr. Basil B. Brim.

WOOD

Two Wood County physicians were honored with 50-Year Pins of the Ohio State Medical Association at the January meeting of the Wood County Medical Society. They are Dr. Elmer A. Powell, of North Baltimore, and Dr. Darley Ward, of Pemberville. Presentations were made by Dr. Paul F. Orr, Perrysburg, Fourth District Councilor. Dr. F. D. Halleck, of Bowling Green, and Dr. Will Rheinfrank, Perrysburg, previously received similar recognition.

Dr. Powell is confined to a hospital because of illness, while Dr. Ward is still in active practice.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

CUYAHOGA

The regular meeting of the Academy of Medicine of Cleveland was held on January 15 in the Medical Library Auditorium.

Following dinner, Dr. Wallace Graham, of the Faculty of Medicine, University of Toronto, spoke on "The Diseases That Affect the Joints."

The afternoon program consisted of a panel discussion concerning the treatment of arthritis. The following speakers discussed the subject under the topics indicated:

"Natural Course of Rheumatoid Arthritis in Children." Dr. John H. Kennell, senior instructor in pediatrics.

"Natural Course of Rheumatoid Arthritis and of Degenerative Joint Disease," Dr. Robert M. Stecher, assistant clinical professor of medicine.

"Conservative Management of Arthritis," Dr. Paul J. Vignos, Jr., senior instructor in medicine.

"Use of Hormones in Arthritis," Dr. William S. Clark, assistant professor of medicine.

"Surgical Management of Arthritis," Dr. Charles H. Herndon, assistant professor of orthopedic surgery.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

STARK

Dr. J. J. Longacre, professor of reconstructive and plastic surgery, University of Cincinnati College of Medicine, spoke on "The Management of Problems in Practice by the Plastic Surgeon," at the January meeting of the Stark County Medical Society in Canton.

The February 11 meeting speaker was Dr. Alfred Ebel, assistant chief, Physical Medicine and Rehabilitation Service, Bronx Veterans Administration Hospital, and active in a number of other rehabilitation programs. He was assisted by Mr. Morris Vogel, chief of physical therapy at the V. A. Hospital, Bronx.

The subject was "The Value of Physical Medicine in the Management of Muscular Dystrophy." The same morning, a clinical demonstration was presented at the Central Y. M. C. A. Health Club.

SUMMIT

Dr. Herbert E. Sloan, Jr., assistant professor of thoracic surgery, University of Michigan School of Medicine, was guest speaker at the February 2 meeting of the Summit County Medical Society on the Akron University campus. His subject was "Cancer of the Lung."

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

TUSCARAWAS

Dr. Frederick Wentworth, chief of the Division of Contagious Diseases, Ohio Department of Health, spoke on the subject, "Recent Trends in Communicable Disease Control," at the January 14 meeting of the Tuscarawas County Medical Society.

At the February 11 meeting, Dr. Max Shaweker spoke on the subject, "Pathology of the Breast."

Eighth District

(COUNCILOR: ROBERT S. MARTIN, M. D., ZANESVILLE)

ATHENS

Clark C. Grubbs, assistant supervisor of the Claims Division for the Ohio Industrial Commission, was guest speaker at the February 9 meeting of the Athens County Medical Society in Athens. He spoke on "The Mechanics of Filing and Processing Claims and Fee Bills Under Workmen's Compensation Laws."

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

HOCKING

Dr. M. H. Cherrington, Logan, was honored at a recent meeting of the Hocking County Medical Society for his long and faithful service in the medical profession. He was presented the 50-Year Pin and Certificate of the Ohio State Medical Association by Dr. C. L. Pitcher, Portsmouth, Ninth District Councilor.

SCIOTO

The January 11 speaker for the Scioto County Medical Society was Dr. Thomas E. Shaffer, Columbus, whose subject was "Respiratory Difficulties in Newborn Infants."

"Industrial Commission Procedures at the Atomic Plant," was the subject discussed by R.



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Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Speaker for the January 18 meeting of the Columbus Academy of Medicine in the Columbus Gallery of Fine Arts was Dr. Jerome Conn, professor of internal medicine, and director of endocrinology and metabolism and Metabolic Research Laboratory at the University of Michigan Medical School. His subject was, "Hypoglycemia and Hypoglycemic Reaction."

PICKAWAY

At the January meeting of the Pickaway County Medical Society, Clark C. Grubbs, assistant supervisor of the Claims Division, Ohio Industrial Commission, discussed procedures in filing of Workmen's Compensation Claims.

Members had as their guests their office nurses, assistants and secretaries. Dr. J. M. Hedges, president, presided at the meeting. Dr. E. L. Montgomery, secretary, reported that the reaction was spontaneous and unanimous in approval and appreciation. "We are sure the relations between physicians and the Industrial Commission will be expedited and more pleasurable since this address," he said.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

ASHLAND

The Ashland County Medical Society has announced arrangements of its featured speakers for monthly meetings through June. Exact topics on which guest speakers will base their talks have not been announced in all cases, but the general field is indicated.

At the January 8 meeting, Dr. Delnos Greeneltch, chief of anesthesia at the Ohio Valley General Hospital, Wheeling, W. Va., was speaker. The February 5 meeting was "Ladies Night," for which the program was principally entertainment.

Speakers for coming meetings have been announced as follows:

March 5—Dr. John Sheldon, professor of medicine and chief of allergy, University Hospital, Ann Arbor, Mich.

April 2—Dr. Robert Bassett, assistant professor of neurosurgery, University Hospital, Ann Arbor, Mich.

May 7—Dr. R. L. Haas, associate professor of obstetrics and gynecology, University Hospital, Ann Arbor, whose subject will be "Changing Aspects of Obstetrics."

June 4—Dr. William Marsh, Akron, whose talk will be in the field of dermatology.

HOLMES

At a recent meeting the Holmes County Medical Society by official action established a Holmes County Nurses Loan Fund. Funds will be made available to any girl high school graduate of Holmes County. The amount of an individual loan will be $400.00 for a three-years' training period. It is stipulated that any girl receiving a loan must agree to return to the Pomerene Memorial Hospital of that county for one year after graduation.

RICHLAND

Approximately 50 members of the Richland County Medical Society met at the Mansfield General Hospital on January 21. Dinner was served at the hospital and a business meeting and program followed.

Dr. Donald L. Mahanna, associate in the Department of Medicine, Ohio State University College of Medicine, and secretary of the Central Ohio Heart Association, addressed the group. His subject was "Rheumatic Fever."

Activities of Woman's Auxiliary . . .

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IN MEMORIAM

The death of Jeane L. Geer, wife of Dr. Joseph A. Geer, of Lancaster, is deeply regretted. Sympathy is extended to Dr. Geer, their three children and to Mrs. Geer's family.

A. M. E. F.

Mrs. George W. Cooperrider reports that 10 additional County Auxiliaries have contributed to the American Medical Education Foundation. They are: Fairfield, Logan, Richland, Licking, Fayette, Sandusky, Washington, Erie, Hamilton, Mahoning.

LUCAS

Mrs. Boni E. Petcoff, president of Lucas County Auxiliary, conducted a Board meeting at the Academy Building on January 6.

Captains, co-captains and lieutenants of the Mothers' March on Polio received material and instructions at a tea held in the Academy Build-

ing on January 5. Mrs. John Buck and Mrs. Hazen Hauman, co-chairmen of the drive, named Mrs. Alex Johns, chairman of the tea. Mrs. B. V. Scheib and Mrs. William H. Bonser served as co-chairmen.

The English Course, under the chairmanship of Mrs. Paul Hohly, resumed class on January 7.

The Child Study Development Group met at the home of Mrs. R. P. Whitehead, Jr., on January 8. Mrs. Wendell Schlichting led a discussion on children in the 4 to 5-year level following the showing of a film on "Shyness."

The evening Live Issues of Today Study Group met on January 8 at the home of Mrs. Max Schnitker, who was assisted by Mrs. Theron Hopple. Mrs. Ralph Zucker led the discussion on "The Fifth Amendment."

Plans for the traditional Academy-Auxiliary supper dance to be held February 13 in the Commodore Perry Hotel were discussed at a meeting in the home of the chairman, Mrs. Franklin Earnest III, on January 8. The committee includes Mrs. William Mewborn, social chairman; Mrs. Henry D. Cook, assistant dance chairman; Mrs. John Dickie, tickets and reservations; Mrs. W. H. Eyster, Jr., telephone; Mrs. Ralph Zucker, costumes; and Mrs. Samuel D. Zuker, food.

RICHLAND

A luncheon meeting of Richland County Auxiliary was held on December 15. Mrs. Paul A. Blackstone, president, reminded the group that the Auxiliary was organized just 15 years ago, on December 15, 1938, and was the first county group organized in Ohio. Mrs. J. L. Stevens served as the first president.

A $10 donation was voted to the TB association. Mrs. Paul Lee reported on her visits to the Golden Age club at Friendly House and plans were made to furnish cookies and ice cream for the club's Christmas party. Mrs. Edward Beilstein presented a program on *Today's Health.*

STARK

Members of the Stark County Auxiliary had their husbands as guests at a special meeting on December 8 at the Canton Woman's Club. Rabbi George B. Lieberman, spiritual leader of Temple Israel, presented a literary review.

The annual Christmas tea was held at the home of Mrs. J. V. Stewart on December 15. Mrs. L. M. Snively served as hostess chairman with Mrs. Dale Hart, co-chairman. Members made their annual contribution of children's gifts and toys for the Visiting Nurse Association.

TUSCARAWAS

The annual Christmas dinner party of Tuscarawas County Auxiliary was held at the home of Mrs. E. L. Miller, Dennison. The hostess was assisted by Mrs. Alvin Greenlee of Uhrichsville; Mrs. Roy Wilson, Dennison; and Mrs. C. J. Nicosia of Bowerston.

Mrs. Roy Demuth of Gnadenhutten discussed

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GYNECOLOGY & OBSTETRICS—Gynecology Course, two weeks, starting June 7. Vaginal Approach to Pelvic Surgery, one week, starting March 29. Obstetrics Course, two weeks, starting March 29. Combined Course in Gynecology & Obstetrics, three weeks, starting April 19.

MEDICINE—Two-Week Intensive Course starting May 3. Electrocardiography & Heart Disease, two weeks, starting March 15 and July 12.

PEDIATRICS—Two-Week Intensive Course starting April 5. Congenital & Rheumatic Heart Disease in Infants & Children, one week, starting April 19 and April 26.

UROLOGY—Intensive Course, two weeks, starting April 19. Ten-Day practical course in Cystoscopy every two weeks.

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traditional Moravian Christmas customs, presented each member with a Moravian beeswax candle and displayed a Moravian manger scene made of moss.

Auxiliary members assisted in preparation for the holiday season at Tuscarawas Valley Sanatorium.

TRUMBULL

The December meeting of the Trumbull County Auxiliary was held jointly with the Medical Society. A cocktail hour was enjoyed at the Hotel Warner followed by a dinner-dance at the Trumbull Country Club.

A Christmas party was given at the home of Mrs. Frank LaCamera for part of the student nurses at Trumbull Memorial Hospital. Mrs. Harold Muter, a member of the Hospital Auxiliary, entertained the remainder of the nurses at her home, assisted by members of the Medical Auxiliary.

A dryer was presented to the Trumbull Memorial Hospital student nurses and a teaching mannikin with movable parts was given to St. Joseph's Riverside Hospital.

VAN WERT

A new organization—"Babies Auxiliary"—is sponsored by the Van Wert County Auxiliary as a method of raising money for purchase of equipment or other improvements in the hospital nursery. Each baby born at the hospital will be invited to become a member of the "Babies Auxiliary" by payment of a $1 enrollment fee by his parents. In return, the baby will receive a special certificate of membership for inclusion in his baby book and his name will be placed on an honor roll in the hospital corridor.

Nurses of Van Wert County Hospital were guests of the Van Wert Auxiliary at the December meeting held at the home of the president, Mrs. F. A. McCammon. Nurse recruitment and civil defense were discussed. After the business session, a social hour was enjoyed and refreshments were served.

WASHINGTON

Members of the Washington County Auxiliary met in December for a potluck dinner at the home of Mrs. F. E. Eddy, with Mrs. E. W. Hill, Jr., serving as assistant hostess. Packages of clothing, toys and candies for underprivileged children were wrapped under the direction of Mrs. Edgar Northrup.

Mrs. M. S. Muskat presided at the business session, at which reports were submitted by Mrs. G. E. Huston, Mrs. W. E. Turner, Mrs. Donald Williams and Mrs. Northrup.

Auxiliary members were guests of the Parkersburg Auxiliary at a luncheon on January 12.

(Editor's Note—Due to limited space, additional Auxiliary notes submitted for this issue will be printed in a subsequent issue.)

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Dr. Fred B. Harrington, director of health in the Steubenville Civil Defense Corps, was one of three Ohio persons who received awards of the Freedoms Foundation of Valley Forge, Pa. Governor Frank J. Lausche presented the awards during a state-wide civil defense meeting.

FOR SALE: Cambridge "Simpli-Trol" Model Portable Electrocardiograph. Excellent condition. $100. W. H. Miller, M. D., 328 E. State St., Columbus, Ohio; MAin 3743.

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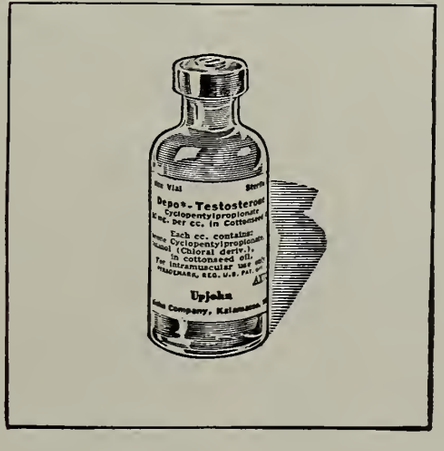
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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Inhalation Therapy and Resuscitation, by Meyer Saklad, M. D., ($7.50. *Charles C. Thomas Co., Springfield, Ill.)* This rather complete monograph deals in detail with the various methods of producing ventilatory resuscitation giving the advantages and disadvantages of each. The author presents a working classification of hypoxia which helps the reader understand the effects of oxygen administration on the blood gases and thereby to determine the possibility of satisfying the tissue's oxygen want by the method under consideration. In this way he also gives an evaluation of the various pieces of equipment which are offered for this purpose.

Textbook of Surgery, Edited by H. F. Moseley, M. D., ($15.00. *C. V. Mosby Company, St. Louis 3, Mo.).* This noteworthy contribution by the faculty at McGill University presents to the undergraduate the facts by which he can come to understand the principles of surgery, appreciate the value of the clinical signs and symptoms and methods of examination so as to arrive at an accurate diagnosis. It also teaches him when an operation is indicated and gives him a fair idea of what is the best surgical treatment. In short, this book is the guide to the graduate education and training which the modern surgeon must have, if he is to serve his public as they have a right to expect.

Manic-Depressive Disease, by John D. Campbell, M. D., ($6.75. *J. B. Lippincott Co., Philadelphia 5, Pa.).* Here is presented a refreshing new approach to this distressing and all too frequent disorder. Manic-Depressive disease is presented as a physiologic disturbance in the autonomic nervous system. In this way the author is able to group a set of new symptoms as he has observed them in these patients while you and I will recognize them as frequently occurring in the practice of each of us. Instead of losing us in the mysticism of the unconscious, Dr. Campbell shows us that many patients are suffering from endogenous cycles of mood disturbances. He then goes into detail to explain what can be done to prevent these cyclic disorders. With these data in mind, the physician is able to recognize this disease early in its course.

Psychosomatic Research, by Roy Richard Grinker, M. D., ($3.50. *W. W. Norton & Company, Inc., New York 3, N. Y.).* A most timely book indeed. This subject has grown so fast and has been accepted with such enthusiasm that no one has stopped to evaluate, critically, its value to clinical medicine. It is refreshing, therefore, to have such an experienced and brilliant clinician state that psychosomatic research in its efforts to link specific emotional states with specific somatic symptoms of the sick person has gone astray. "Psychosomatic means more than a kind of illness," he writes; "it is a comprehensive approach to the totality of a process that takes in many systems: psychic, somatic, social and cultural." With this, we have no quarrel. The need at all times is for a balanced appraisal of the man as a biologic unit and the impact of his environment on such a human being.

The Year Book of Medicine 1953-1954 Series. Edited by Six Outstanding Internists, ($6.00. *The Year Book Publishers, Chicago 11, Ill.).* Still an indispensable text to those who wish to keep up with modern medicine. It is essential if for no other reason than to point out important contributions which we have missed. It however is more than that because of the editorial comment of the abstractor and selector of the material which goes into it.

Blakiston's New Gould Medical Dictionary, (1951 with 1953 Supplement. $9.50. *The Blakiston Company, Inc., 575 Madison Avenue, New York 22, N. Y.).* A modern comprehensive dictionary of terms used in all branches of medicine edited by Harold Wellington Jones, M. D., Normand L. Hoerr, M. D., and Arthur Osol, Ph. D., with the cooperation of an editorial board and 80 contributors, brought up to the minute with a ten-page supplement.

Dictionary of Psychiatry and Psychology, by William H. Kupper, M. D., ($4.50. *The Colt Press, Paterson 3, N. J.).* This is an illustrated condensed Encyclopedia of these fields. A handy volume indeed in these days of volumes of literature dealing with these subjects.

Health Principles and Practices, by C. V. Langton, Dr. P. H., and C. L. Anderson, Dr. P. H., ($4.25. Illustrated. *The C. V. Mosby Company, St. Louis 3, Mo.).* This book places its primary emphasis properly upon the basic principles of health promotion. It succeeds in giving its reader functional health knowledge.

Animal Sanitation and Disease Control, by Ralph R. Dykstra, ($3.75. Fourth Edition. *The Interstate, Danville, Ill.).* A distinguished teacher of veterinary medicine attempts to tell of the importance to the nation of adequate veterinary service and to lay a foundation in the minds of his readers for control of disease through the prevention of animal ailments.

Antibiotics, by Robertson Pratt, Ph. D., and Jean Dufrenoy, D. Sc., ($7.50. Second Edition.

J. B. Lippincott Co., Philadelphia 5, Pa.). This text presents in a succinct, integrated plan the facts and principles of fundamental and permanent value relating to antibiotics.

Planning Guide for Radiologic Installations, by Wendell G. Scott, M. D., ($8.00. *The Year Book Publishers, 200 East Illinois St., Chicago 11, Ill.),* has been prepared by the committee of the American College of Radiology, and is a joint endeavor of radiologists, manufacturers of equipment and film, The American Institute of Architects and The American Hospital Association.

Potassium Metabolism, Edited by **L. J. Filer,** Jr., M. D., (Apply. *M & R Laboratories, Columbus 16, Ohio).* This is the report of the Sixth Pediatric Research Conference, Irvine McQuarrie, M. D., Chairman. It is therefore a condensed presentation of some of the problems warranting further investigation. It gives the reader in some 50 pages a correlated story of what is known and what should be studied next in relation to the role of potassium in the metabolism of the human, especially the child.

Distribution of Plants in the United States Which Might Be of Clinical Significance to the Practicing Allergist, by Robert G. Lovell, M. D., Kenneth P. Mathews, M. D., and John M. Sheldon, M. D. Reprint from the *University of Michigan Medical Bulletin* 1953: 17 pp., 80-96. This is a collection of up-to-date information regarding the geographical distribution of grasses, trees, and weeds which do produce pollens that sometimes are of clinical significance.

A Study in Manic-Depressive Psychosis, by Ake Stenstedt, *(Ejnar Munksgaard, Norregade 6, Copenhagen, Denmark).* Presents the results of clinical, social and genetic investigations from the Psychiatric Clinic of Karolinska Institute of Stockholm. The genetic analysis shows that with a higher degree of probability manic-depressive psychosis follows a dominant type of inheritance. It also suggests that unfavorable environmental conditions in childhood are important in increasing the risk for psychosis in the siblings of the probands.

Your Children's Health, by J. Roswell Gallagher, M. D., ($0.40. *Science Research Associates, 57 West Grand Avenue, Chicago 10, Ill.).* This is one of "The Better Living" books for parents and teachers. It has been designed to furnish adults with practical, up-to-date information about the health of children. It covers most of the areas where there is likely to be trouble. It has been written largely from the viewpoint of "keeping one's health."

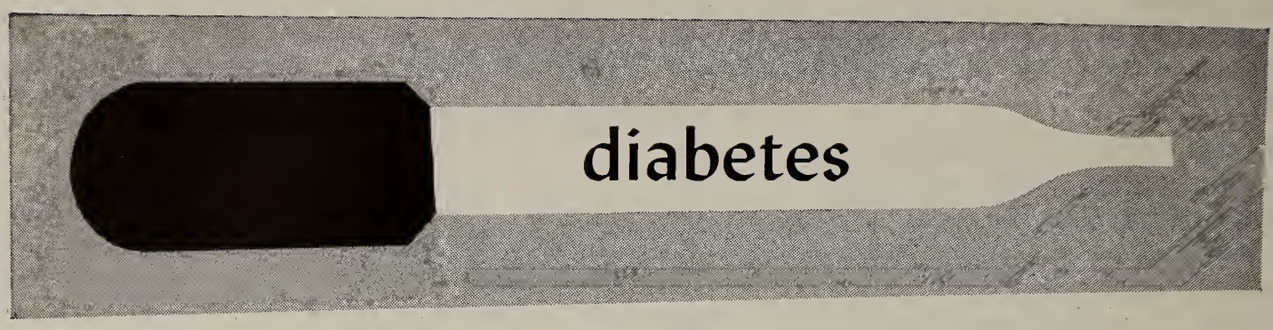
Democratic Leadership in Physical Education, by Maud L. Knapp and Frances Todd, ($1.25. *The National Press, Millbrae, Calif.).* As the authors point out the parallel between sports and democracy is striking. Democracy is based upon law, equality and justice and so is sport. But democratic skills do not accrue just automatically from exposure to or participation in sports. Education from competent leaders is a requisite.

Parental Care and Its Evolution in Birds, by Samuel Charles Kendeigh, Illinois Biological Monographs, Vol. XXII, Nos. 1-3, ($5.00 cloth—$4.00 paper. *University of Illinois Press, Urbana, Ill.).* The survey of parental behavior presented by this survey emphasizes the prevalence of joint responsibility of male and female on nearly equal terms in incubation as well as in the other phases of nest life. Behavior depends upon the organization of the nervous and endocrine systems. Much of behavior is conditioned by the physiologic state of the individual. This varies with many environmental factors such as temperature regulation, energy regulation, gonad development and endocrine efficiency. For a behavior pattern to be expressed, the organism must receive the proper stimuli and be in the appropriate physiologic state.

The Distribution of Subcutaneous Fat in Childhood and Adolescence, by Earle L. Reynolds. (Monograph, Vol. XV, Serial No. 50, No. 2 of *The Society for Research in Child Development, Fayerweather Hall, East, Northwestern University, Evanston, Ill.).* This is the report of a part of the studies that have been going on under Dr. L. W. Sontag of the Fels Foundation at Yellow Springs, Ohio, for the past 13 years. This Foundation under Dr. Sontag is to be congratulated upon its vision in so planning the investigations that the succeeding generation of research workers can continue the collection and analysis of similar data. It seems likely that only in such longitudinal study of human beings can we expect to reach the truth of growth and development. Any less has frequently resulted in a complete loss of a lifetime of brilliant research. This study of soft tissue is a good example of how such studies should be conducted.

Health of Workers in the Chromate Producing Industry, prepared by the Staff of the Division of Occupational Diseases of the U. S. Public Health Service. (50¢ from the *Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.* A limited number are available free from the Division of Occupational Diseases Public Health Service, Fourth St. and Independence Avenue, S. W., Washington, D. C.). A report of a comprehensive clinical and environmental study of the health hazards in the industry together with the recommendations for the control of such hazards.

Half, by Jordan Park. A Lion Original Pocket Book (25¢. *Lion Books, 270 Park Ave., New York 17, N. Y.).* A new novel about the "man" who tries to change his sex.



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1. Blotner, H., and Marble, A.: New England J. Med. *245*:567 (Oct. 11) 1951.
2. Steine, L.: GP *8*:45 (July) 1953.

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Vol. 50 April, 1954 No. 4

JONATHAN FORMAN, M. D., *Editor*

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Asst. Managing Editor

Resuscitation of the Newborn——A Clinical Review

J. E. MORGAN, M. D., and CARMEN T. REYES, M. D.

RESUSCITATION of the asphyxiated newborn infant has always been an important problem for those of us practicing obstetrics. In the past, with labor and delivery being conducted with little or no anesthesia, only a very small percentage of babies were born needing resuscitation. Those who did were usually born after a long and difficult labor with a traumatic delivery, or after a premature labor. In recent years, with the increasing tendency toward the administration of analgesia during labor, and delivery by prophylactic forceps under general anesthesia, the importance of resuscitation of the newborn has markedly increased.

Babies from such labors, narcotized by the effect of drugs administered to the mother, seldom cry spontaneously and only expert care and attention in the minutes immediately following birth can keep the newborn mortality and morbidity rate at a figure which justifies the copious administration of drugs to relieve the mother's pain. Poor or inadequate resuscitation of these narcotized babies may vitiate the results of an otherwise carefully conducted pregnancy, well-managed labor, and good, or even brilliant forceps delivery.

Even though these babies survive birth, an appreciable number develop atelectasis and run a morbid course for the first week or two of their lives, requiring constant care and attention. It therefore behooves us all to occasionally review the physiology concerned in respiration and resuscitation, and our technique. In the following discussion, I will try to keep the viewpoint entirely clinical, only presenting the physiology concerned in rather broad terms.

Submitted September 29, 1953.

The Authors

● Dr. Morgan, Parma, Ohio, is chief, department of obstetrics, Evangelical Deaconess Hospital, Cleveland; and head of department of gynecology, St. John's Hospital, Cleveland.

● Dr. Reyes, Cleveland, is resident physician, department of obstetrics, Deaconess Hospital.

METHODS REQUIRING LEAST RESUSCITATION

What is the answer to this problem? Dr. Read[1] feels that the solution is "Natural Child Birth," which is essentially a return to delivery without analgesia or anesthesia. In spite of Dr. Read's insistence that a normal labor and delivery are not accompanied by pain, the majority of the women under my care do not agree with him, and I cannot feel that a return to this type of obstetrical care is ever going to become universally popular in our present state of civilization.

The more widespread use of terminal low spinal or saddle block anesthesia will be helpful, because certainly the elimination of inhalation anesthesia lessens the babies' respiratory depression. Women may be given adequate doses of analgesic drugs during labor, and if delivered under spinal anesthesia, the babies almost always cry spontaneously. Conversely, if the women are given no analgesic drugs during labor, and delivery is under one of the inhalation anesthetics, the babies show little depression. It seems to be

the combination of analgesic drugs during labor, and delivery under inhalation anesthesia that produces the deeply narcotized babies.

We might also interject here that we must also remember that the premature infant does not tolerate either drugs administered to the mother for analgesia or inhalation anesthesia as well as the full term infant. The woman in premature labor should be carried through labor with no analgesia and delivered under low spinal, local, or no anesthetic, if we are to reduce our present high mortality rate among prematures.

Universal application of spinal anesthesia, however, is a far from practical solution. There are still occasional undesirable complications, and the technique of its administration has not been acquired by all. There is also the practical element of the physician's time. Spinal anesthetics must be administered at a specific moment in the course of labor to be most effective. Frequently the physician is not able to be present at that specific moment and may not have adequately trained personnel present to give it for him. Therefore, for some time to come, there will probably be an increasing tendency the country over to administer analgesic drugs during labor, and delivery with the patient under some form of inhalation anesthesia. As a consequence, all of us practicing obstetrics must pay more and more attention to the efficient resuscitation of more or less narcotized newborns.

MECHANICAL AIDS TO RESUSCITATION

In the past few years, several ingenious machines have been placed on the market to aid in resuscitation. These machines, however, are no cure-all. The mere purchase of one of them by the hospital administration does not assure adequate resuscitation of newborn infants. The machines are only as intelligent as the person operating them, and all too often the resuscitation machine clicks merrily away but little details have been neglected which make the efforts of the machine entirely fruitless. Therefore, a considerable portion of this discussion will be devoted to explaining the correct use of these mechanical adjuncts to resuscitation.

Those most in use fall into two general classifications. One[2] is simply a pump which administers intermittent puffs of gas under positive pressure by way of a face mask. Both the rate of administration and the amount of gas administered can be regulated with simple thumb screws. The mask designed with this machine has a semiflexible rubber tube protruding from its center which holds the mouth open and keeps the tongue out of the way. This makes any other airway unnecessary. This machine simply does what we used to do with mouth-to-mouth breathing except that we can utilize any percentage of oxygen delivered in intermittent puffs, whose rate and volume can be regulated. No provision is made to exhaust the gas from the lungs, expiration depending upon the natural elastic recoil of the chest wall, the mechanism being so arranged that there is no obstruction to the egress of the gas.

Another class of machines[3] is a little more complicated in conception. These administer gas until they are blowing against a certain pressure, then reverse and exhaust the gas until a certain fixed negative pressure is reached. The mask provided with this machine has no tube to hold the mouth open and depress the tongue, hence it is absolutely essential to introduce a small airway when using this machine. Both classes of machines are efficient and perfectly safe when used intelligently and with close attention to detail. I prefer the first type but that may be because of long usage and habit.

In the past couple of years, an extremely complicated apparatus has been devised, called the Blocksom Air-Lock[4] which some feel is the last word in resuscitating infants. Opinions as to the worth of this apparatus vary. It will take wider usage and some time to clarify our ideas on the Air-Lock, so in the following discussion I will confine my remarks to the use of one of the standard machines.

CLINICAL APPLICATION

Let us now take the case of a hypothetical delivery and follow through the steps of resuscitation as they usually occur. We will suppose that the mother has received considerable analgesic medicine during a labor of moderate length and that the baby has been delivered at term with an episiotomy and low forceps under inhalation anesthesia. Such babies differ greatly and apparently unexplainably in regard to their need for resuscitation.

Immediately upon delivery, we should make a quick estimate of the difficulty we expect to encounter in resuscitating the individual child. A goodly number of these babies are nice and pink, have good muscle tone, and begin to gasp, breathe, or even cry almost immediately. Certain others are of a reddish purple hue indicating a certain amount of asphyxia and anoxia, muscle tone is not good, and they make little or no effort at respiratory motion. Still others are a pallid cyanotic hue, completely limp, with complete lack of muscle tone, and make no effort to breathe. The heartbeat over the precordium may not be palpable, and even the pulse at the navel is weak, rapid, and thready.

It is obvious at once that the first class needs little or no help, the second class needs attention, but are usually resuscitated easily. The third class are the ones that need immediate and efficient attention in order to avoid morbidity and mortality. The anesthetist is frequently a help immediately after the birth by flushing the pa-

tient with oxygen so that the baby receives an extra supply while the placenta is still attached.

The prime considerations in handling asphyxiated babies are gentleness, maintenance of body temperature, and oxygenation of their blood and tissues. If these three aims are effectively and quickly carried out, the babies can be maintained for an indefinite period of time with no harm done and spontaneous voluntary respiration almost invariably begins. If, however, the baby is mauled and traumatized, the body temperature drops, and anoxia deepens, the baby rapidly progresses into an irreversible state of shock and asphyxia. The old methods of spanking, swinging, manual artificial resuscitation (squeezing the chest) and dousing in, or with cold water should be considered entirely obsolete.

CLEARING THE AIRWAY

The first procedure necessary is to clear the baby's airway of blood, amniotic fluid, or mucous, which might be aspirated into the trachea and bronchi with the first inspiratory effort. How this should be accomplished has been a matter of debate for many years. Some have advocated intubation of the trachea by direct laryngoscopic methods in all of these severly asphyxiated infants. This is a highly technical procedure and should be done only by those well trained in its application. Flagg,[5] who is a prominent exponent of this method, has been recently quoted as saying that he believes the merit of the procedure is not the aspiration of obstructing material, but the direct introduction of oxygen into the trachea. I do not believe direct intubation is necessary. I believe that it is sufficient to strip the mucous out of the trachea with the external finger and aspirate it from the mouth, nose, and nasopharynx with a soft rubber catheter.

Care should be taken to introduce the catheter into the region of the glottis in order to aspirate any material that might be sucked into the larynx and trachea from this point. When untrained personnel are effecting this procedure, you will frequently see the catheter introduced for a distance of four or five inches. If the nurse is asked what she is doing, the usual reply is that she is aspirating mucous out of the trachea. Of course it is obvious that a catheter thus introduced by an untrained operator is simply going down the esophagus and is a completely futile procedure for aspirating the trachea. Recently it has been suggested that aspiration of stomach contents[6] is a useful adjunct in resuscitating infants, but if that procedure is to be employed, it should be done knowingly and not by a nurse laboring under the illusion that she is aspirating the trachea.

RESPONSIBILITY FOR RESUSCITATION

With the cord severed and the airway clear, we are now ready to begin active resuscitation if the child has not already begun to breathe spontaneously. Two primary questions come up at this time: Where should the resuscitation be done? and, Who should do it? As previously mentioned, the child must be protected against loss of body heat, so it is best to place it in a warm incubator or warm crib. If one of these is not available, and resuscitation has to be extended for any appreciable length of time, placing the child in an adequate size tub of warm water, while proceeding with resuscitation is still an extremely useful procedure and should not be forgotten.

As to the second question, the entire technique of resuscitation should be performed by someone adequately trained and vitally interested in the problem. I can think of no one who should be better qualified than the obstetrician himself. Certainly the welfare of these babies is of vital importance to him and certainly he is the one who should have a better understanding of the physiology of the newborn than anyone present. All too often, these babies are handed over to an inadequately trained nurse while the obstetrician proceeds with the all-absorbing task of repairing the episiotomy. There is no reason why, with a sponge packed into the episiotomy wound to control bleeding, the operator cannot step over to the crib and either actually do, or at least supervise the resuscitation; change his gown and gloves and proceed with the third stage of labor. Probably the next best thing is to have a resident well trained in resuscitation technique. If a resident is not available, one particular nurse should assume responsibility and the baby should not just be handed to anyone who happens to be present and then forgotten.

In the larger institutions, it is becoming common to have a pediatrician in charge of the newborn nursery and to assume charge of the newborn babies almost from birth. Perhaps it might be well in these larger institutions to have a resident in pediatrics spend a certain portion of his time in the delivery room and assume responsibility for the resuscitation. Certainly in the next few days of the infant's life, he will be called upon to diagnose and treat many complications either caused by poor resuscitation or avoidable by good resuscitation. Being present at the time of birth, and having a hand in the resuscitory measures, would give him a much better understanding of these problems.

Now to get back to the problem at hand. We have an infant, separated from its natural supply of oxygen, placed in a warm, favorable environment, but not making any respiratory efforts because of depression from drugs and anesthesia administered to the mother. If left alone, the degree of anoxia will increase rapidly. Snyder[7] has shown that in the period immediately following birth, nature has provided newborns with the ability to tolerate anoxia for a longer period than

they will ever be able to do again throughout their lives. We should not take advantage, however, of this protective mechanism, so kindly provided by nature, but should provide an adequate oxygen supply to the blood and tissues as soon as is conveniently possible. I feel that this can and should be accomplished within two minutes after the cord is severed, and can be safely and efficiently accomplished by the judicious use of one of the resuscitation machines previously mentioned.

TECHNIQUE

Since I prefer the Dann machine,[2] I will brifly review the technique of its use and later mention a few of the points to be observed in using an apparatus of the other type. Several practical and physiological points must be understood and checked before the mask is applied. As already mentioned, this apparatus is simply a pump which administers intermittent puffs of the mixture of oxygen to be used at an adjustable rate and volume. It has been shown that respiration is best initiated if the rate is set at approximately that at which you expect a newborn baby to begin to breathe. This is 30 to 40 times per minute. Next, the valve regulating volume should always be completely turned off.

The mask is then applied to the face with the tube inserted into the mouth above the tongue. The volume administered with each stroke of the machine is then gradually increased until the chest gently expands with each cycle. If resuscitation is begun with the volume too great, alveoli could be ruptured and even pneumo-thorax produced. The mask can and should be held snugly against the baby's face all the time as the elasticity of the lungs and chest wall expell the gas during the neutral part of the cycle. Again let me repeat, there is nothing in the mechanism of this machine which obstructs the outflow of gas during the expiratory part of the cycle. Manual squeezing and pummeling of the chest is entirely unnecessary and needlessly traumatic at this point.

If the chest does not visibly expand with each stroke of the machine, there is something wrong and the cause should be looked for and corrected. The obvious cause is obstruction to the airway. Perhaps there is obstructing mucous. This should be checked for and aspirated. Another, and I believe the most commonly overlooked, cause is poor positioning of the baby. The chin must be well supported and sometimes it is well to elevate the back of the baby's chest slightly in order to straighten the trachea and prevent obstruction from the pressure of the mask. In teaching this point to nurses and residents, I have them watch the anesthetist carrying a patient on a gas machine. With the chin well elevated, the patient's breathing is reflected in the regular oscillations of the bag on the machine. If the chin is depressed, the airway is obstructed, and the attendant oscillations of the bag cease. In the anesthesized patient, the respiratory movements of the chest run the machine, that is expand and contract the bag. With the resuscitation machine, we are attempting the opposite. The machine must cause expansion and contraction of the baby's chest, that is institute respiration. In other words, it is all important to keep the airway clear by supporting the baby's chin.

If a machine of the other type[3] is used, a few minor differences of technique must be observed. The mask used with this machine has no central tube to depress the tongue. Therefore, when using this type machine an infant airway must always be inserted into the mouth to insure an open passage between the mask and the alveoli of the lungs. Used without an airway, this mask is absolutely useless in a high proportion of the cases. Proper position of the baby is equally essential.

With this type machine, little attention need be paid to the rate at which the machine is running because it adjusts its own rate depending upon the size of the cavity to be filled. Over distension of the lungs need not be feared as the machine will only inflate until it encounters a certain predetermined resistance, then reverses and exhausts. Whether this built-in safety factor is entirely to be desired is a moot question because it has been shown that it may take more pressure to effect the first expansion of an atelectatic lung because of the cohesion of the surfaces involved than is necessary for subsequent expansions. For this reason, I prefer the more flexible features of the Dann apparatus with its adjustable volume control.

In using either type of machine, the one essential object to accomplish is the rhythmic intermittent inflation of the lungs. This can be observed as expansion and contraction of the chest wall and upper part of the abdomen. If this is not obviously occurring, something is wrong and the resuscitation is not being efficiently carried out. If either type of machine is correctly used, resuscitation of these depressed cyanotic babies is one of the most gratifying procedures in obstetrical practice.

The cyanotic, or even the pale, ashen gray child changes after a few strokes of the machine, into a nice, rosy pink individual whose tissues are unquestionably adequately oxygenated. We may now carry the child a considerable period of time while waiting for spontaneous respiration to begin with no danger of damage to vital centers or cerebral cortex. After a few moments in this state, spontaneous respiration almost always begins. If it does not begin spontaneously, a little external stimulation, such as rubbing the back, or even a gentle spanking applied to the buttocks, not the small of the back, (danger of adrenal hemorrhage) will initiate it. From here on, care of the infant becomes more routine.

However, infants who were deeply depressed to begin with or in whom considerable difficulty was encountered in resuscitation, should be placed in an incubator and given oxygen for the first 24 hours or so of life until all signs of depression have disappeared.

PHYSIOLOGY INVOLVED

In going over the literature on the subject of resuscitation, certain authorities feel that it is unnecessary, impossible, or even dangerous to try to actively inflate the lungs. The advice is often given to simply clear the airway, keep the baby warm and supply an environment high in oxygen either by a face mask or tracheal intubation so that when the baby spontaneously begins to breathe, it will have oxgyen available. This of course is better than nothing, but I feel that it is entirely inadequate. It does not make use of the Hering-Breuer reflex which is probably the strongest reflex stimulus we have to initiate respiration. On demonstrating this reflex, it can be shown physiologically that inflation of the lungs initiates expiration and deflation of the lungs stimulates inspiration. As further demonstration of the physiology concerned, it can be shown that air blowing down the trachea initiates relaxation of the diaphragm, in other words, expiration, while air blowing up the trachea initiates contraction of the diaphragm, or inspiration.

Coryllos[8] has given an excellent discussion of these reflexes and the part they play in infant resuscitation in an article which I feel is a classic on the subject and which still should be read and reread by everyone dealing clinically with the problem. This reflex rhythmically invoked 30 to 40 times per minute is probably the strongest stimulus to the respiratory center which we have at our command. It is interesting in watching these babies that they frequently begin to breathe at just the rate the resuscitation machine has been running.

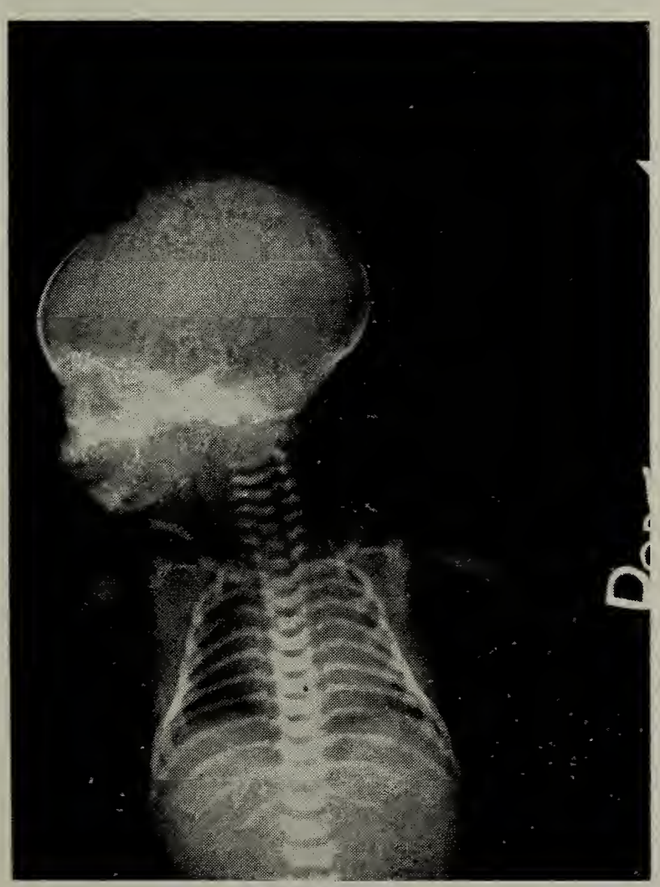


Fig. 1. Chest plate taken immediately after birth. No spontaneous respiratory effort.

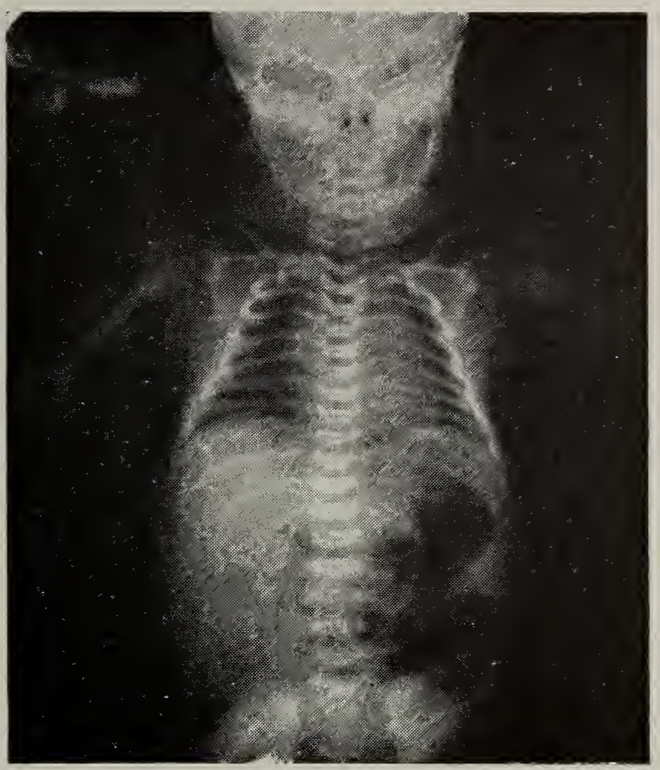


Fig. 2. Chest plate taken after 60 seconds of resuscitation on machine. No spontaneous respiratory effort.

PROOF OF ALVEOLAR EXPANSION

As to whether or not actual inflation and expansion of the atelectatic fetal lung can be accomplished, I present the accompanying radiographs. These were taken immediately following birth of a full term infant whose mother had received analgesic drugs and who was delivered under general anesthesia. Figure 1, taken immediately following birth, shows the lungs completely collapsed, and atelectatic. The child was apneic and deeply cyanotic. Resuscitation was then begun using the Dann apparatus. Figure 2 was taken after 60 seconds of resuscitation. By this time, the baby was a rosy pink color showing good oxygenation of the tissues. The lungs were completely expanded except for one small atelectatic area, and the thoracic cage was well expanded. So far the baby had not made a single spontaneous respiratory movement. Shortly after this, the baby began to breathe on its own.

Another plate was taken after the baby had been breathing on its own for one-half hour. By this time, it had cried lustily and was a normal baby in every respect. Examination of figure 2 and the plate taken one-half hour

later showed little if any difference between the two. In other words, the lungs and thoracic cage had been fully expanded by the resuscitation procedures, and very little change was made by one-half hour of crying and spontaneous respiration.

INTESTINAL INFLATION

These radiographs also illustrate another important point. When a mask is placed over the baby's mouth and nose, and gas is forced in under pressure, a certain portion of this gas finds its way down the trachea and inflates the lungs. This point is proved not only by the obvious signs of oxygenation of the baby's tissues but by the expanded thoracic cage and well aerated lungs shown in figure 2. A certain portion of the gas administered by either type of machine, however, goes down the esophagus and inflates the stomach and upper intestinal tract. This is also visible in figure 2. This gas is less liable to be expelled either by natural recoil of the tissues or by negative pressure from the machine and many workers have warned that over distension of the upper intestinal tract might seriously embarrass respiration.

The only way to inflate the lungs without gas also entering the esophagus is to do as Flagg does and directly intubate the trachea in each case. Because of technical difficulty we would like to avoid this if possible.

Practically, I have had very little difficulty with over distending the stomach. The baby's need for oxygen far outweighs the hypothetical danger. If the stomach does become rather distended it is a simple matter to pick up the catheter previously used to aspirate the naso-pharynx and slip it down the esophagus as a stomach tube. This immediately deflates the stomach. I frequently use this simple procedure if the resuscitation has been at all difficult or prolonged and then danger of respiratory embarrassment from an over inflated stomach simply does not exist.

OTHER PHYSIOLOGICAL CONSIDERATIONS

One other physiological phenomenon sometimes encountered in resuscitation should be mentioned. These machines are sufficiently efficient that it is possible to produce a state of apnea due to hyperventilation. Because of its greater diffusibility rate, the carbon dioxide washes out rapidly and we have a fine pink, well oxygenated baby who doesn't make the effort to breathe spontaneously because there isn't sufficient carbon dioxide in its blood to stimulate the respiratory center. All that is necessary to do is to remove the face mask a few moments and allow a little anoxia to develop. This can often be noted as a slight cyanotic hue beginning to develop and just about then, spontaneous respiration starts. Practically, however, as resuscitation is done the country over, there is much more danger of under oxygenation than of furnishing an over supply.

Whether to use pure oxygen for resuscitation or add a small percentage of carbon dioxide has been another much discussed question. I have used 100 per cent oxygen, and mixtures containing 5 and 10 per cent carbon dioxide and practically I have not been able to observe much difference. I am certain that you can obtain quick and adequate oxygenation of the child with any of these mixtures and as I said in the previous paragraph, if there is any question of over oxygenation, this can be quickly remedied by removing the mask for a short time.

Another point to be remembered is that prompt and adequate inflation of the lungs with the attendant changes in pressure in the lesser circulation is essential for conversion of the fetal circulation to its post-natal pathways. This is another argument that active, well-directed resuscitory measures should be instituted at once.

Any babies requiring more than minimal efforts to resuscitate should be given special care the first several days of life. They should be handled very little; should be placed in an incubator to maintain a favorable environment and should be given oxygen as necessary.

CONCLUSIONS

A safe, efficient, physiological method of resuscitating newborn infants is outlined. This resuscitation procedure should and can be an active dynamic act which changes an apneic, cyanotic infant into a pink, well oxygenated one, who can safely wait the onset of spontaneous respiration.

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EEG Tracings in Epilepsy

A young patient with idiopathic epilepsy of short duration is much more likely to show an abnormal tracing, especially if there is a history of petit mal. On the other hand, an older patient who has had seizures, particularly grand mal, over an extended period is less likely to have an abnormal electroencephalogram. Thus the EEG can provide useful information in many cases of convulsive disorder, but the presence of a normal record by no means excludes this diagnosis.—Henry W. Newman, M. D., San Francisco; *California Medicine*, 80:59, February, 1954.

Pediatric Anesthesia for Dentistry

GILBERT L. GROSS, M. D.

THE dental profession has long been a pioneer in the development of safe and satisfactory anesthesia and analgesia for dental work. Within the past few years it has directed its efforts more toward rehabilitation of children necessitating the developing of safe, suitable, pediatric anesthesia technics for both office and hospital operating room use. It is with these thoughts in mind, then, that we shall present the most salient features of pediatric dental anesthesia and analgesia from the anesthesiologists' point of view.

The Author

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PREOPERATIVE PREPARATION

I. Appraisal of Patient's Physical Condition:

Regardless of whether the procedure contemplated is to be of short duration or lengthy, or whether it is to be performed as an office procedure or in the hospital operating room, a complete history and physical examination of the pediatric patient is imperative.

Naturally, this function is usually carried out by the family doctor or pediatrician, and the pertinent pathological findings revealed to the operator and the anesthesiologist. Without being too detailed, these are some of the things to evaluate.

A. History and Physical Examination

a. Type of labor and subsequent development (any history of anoxia, brain damage, hemorrhage, etc.)

b. History of convulsions: (May have to increase dosage of preoperative barbiturate).

c. History of severe attack of rheumatic fever, nephritis, etc.: (May have impaired function of heart, liver, kidney).

d. History of prolonged bleeding following simple injuries and superficial lacerations. Rule out blood dyscrasias.: (Hemophilia, thrombocytopenia, leukemia, etc.).

e. Chest diseases—TB, bronchiectasis—(influences preoperative and operative care).

f. History of jaundice, edema, cyanosis, helps rule out liver disease and congenital heart disease.

B. Laboratory Study

a. **Blood:** hemoglobin, red blood count, white blood count—serves as added check on absence or presence of anemia and oxygen carrying power of blood. A routine test for syphilis should also be included.

b. **Urinalysis:** Specific gravity, (dehydration) —albuminuria, (kidney damage) glycosuria, (rule out diabetes of renal or endocrine nature).

The above laboratory tests are simple, quick, to perform, and yield important data. When the patient is in the hospital, they are performed routinely without difficulty. The office patient (out-patient) may bring the results of these tests with him as performed by his family doctor or pediatrician.

II. Premedication:

A. Indications and Functions

We would all be loath to relinquish the many advantages gained from the use of pre-anesthetic medication for adults. Our experience, coupled with the experience of others, has shown that these same agents and technics may be applied quite beneficially as well as to pediatric anesthesia. The functions of premedication are five in number:

a. Psychic depression or hypnosis;
b. Heightening of the pain threshold;
c. Reduction of reflex irritability, metabolism and vagal effects;
d. Reduction of mucous secretions;
e. Counteraction of undesirable side actions of the anesthetic agent or agents.

Morphine is the most common opiate used and it possesses three useful premedicative properties:

a. Produces a reduction of reflex irritability;
b. Produces a reduction of metabolism;
c. Produces a certain amount of analgesia.

Scopolamine and Atropine are the most commonly used of the belladonna group and they act to:

a. Depress mucous secretion;
b. Depress vagal reflex activity;
c. Counterbalance the respiratory depression of morphine;
d. Produce psychic sedation.

The short acting barbiturates are most often employed for premedication because of their prompt onset of action and quick recovery period. The two barbiturates most commonly used are

Presented before Cleveland Society for Advancement of Dentistry in Children, March, 1953.

Submitted November 17, 1953.

nembutal® and seconal,® and they are used to produce hypnosis as well as to protect against convulsions produced by various drugs—e. g., cocaine, pontocaine,® procaine and other local anesthetic agents.[2]

B. Dosage Chart

A dosage chart which we have found satisfactory for our needs is the one developed and in current usage by the anesthesia department of the Children's Medical Center, Boston, Massachusetts.

TABLE FOR PREOPERATIVE MEDICATION FOR INFANTS AND CHILDREN

Age	Average Weight	Seconal or Nembutal	Morphine	Scopolamine or Atropine	Demerol
Newborn	7 lbs.	.....	.....	0.065 mg.	.....
6 mos.	16 lbs.	30 mg.	.....	0.1 mg.	.....
1 yr.	21 lbs.	50 mg.	1.0 mg.	0.1 mg.	10 mg.
2 yrs.	27 lbs.	60 mg.	1.4 mg.	0.2 mg.	20 mg.
4 yrs.	35 lbs.	90 mg.	2.4 mg.	0.2 mg.	25 mg.
6 yrs.	45 lbs.	100 mg.	4.0 mg.	0.2 mg.	40 mg.
8 yrs.	55 lbs.	120 mg.	5.4 mg.	0.3 mg.	45 mg.
10 yrs.	65 lbs.	150 mg.	6.0 mg.	0.3 mg.	50 mg.
12 yrs.	80 lbs.	200 mg.	8.0 mg.	0.4 mg.	50 mg.

1. This chart is a guide only, to be followed for average, well developed patients. Reductions must be made in medication for subnormal patients.
2. Scopolamine is advocated for all patients except those undergoing intrathoracic operation, for whom atropine is preferable.
3. Patients receiving avertin® should have scopolamine, but **no morphine or barbiturate.**
4. No morphine or barbiturate is to be given a patient under 60 months of age.
5. Nembutal® is to be dissolved in 10 cc. of water and injected rectally, with syringe and catheter, **90 minutes** before operation.
6. Demerol® or morphine and scopolamine are to be given hypodermically **60 minutes** before operation.
7. Before ether, cyclopropane, or pentothal anesthesia, give nembutal,® demerol® and scopolamine, as suggested by chart.
8. **Approximate dosage:** Barbiturate: 2½ mg. per pound of body weight; morphine: ¾ mg. 1 yr. of age; demerol®: ⅔ mg. per pound of body weight.

In dealing, however, with dental cases on an out-patient basis (office), certain modifications relative to preoperative medication must be made. For these patients, one is anxious to obtain as many benefits from the premedication as possible without overdepressing the patient or prolonging the postoperative recovery period. Therefore, scopolamine, as well as the opiates or their substitutes, are omitted from the premedication regime. The medication given is limited to a short acting barbiturate, e. g., nembutal® or seconal® combined with a drying agent (atropine). This combination is administered one hour preoperatively by oral, rectal or parenteral routes. Thus, by avoiding the use of scopolamine and an opiate, there tends to be less postoperative somnolence and excitement and the patient may leave the office in a more normal state more quickly.

On the other hand, the patient being operated upon in the hospital receives the full treatment. He receives his opiate and scopolamine one hour preoperatively and his barbiturate two hours preoperatively. The duration and character of postoperative recovery period here is in direct proportion to the type of intra-operative anesthesia management, as well as to the preanesthetic medication management.

Since the patient stays in the hospital postoperatively, a slightly longer recovery period produces no special problems.

C. Technics of Administration and Handling

Regardless of whether the patient is handled as an out-patient, or as an in-patient, he is prepared for the procedure by his parents the night before the operation. A very simple explanation, in general terms, of what is going to take place is sufficient. Briefly, he is told that he will receive some medication by the oral, rectal, or parenteral routes which will make him feel drowsy and make his mouth dry. Following this, a doctor will blow some sweet smelling gases across his face and he will fall asleep quickly and awaken to find himself with his parents.

(a) **Out-Patient:** The patient is brought to the office anteroom two hours preoperatively and one and a half hours preoperative premedication is administered by the rectal, oral or parenteral routes, (nembutal® and atropine). Patient is induced with nitrous oxide and oxygen blown across face (80-20 mixture) followed by open drop vinethene.® Ether is added if necessary. Mouth gag inserted quickly and extractions done. This technic is suitable only for short procedures.

SHOULD HAVE ON HAND FOR INSTANTANEOUS USE:

1. Source of oxygen and face mask that fits properly;
2. Suction equipment assembled and in working order;
3. Laryngoscope and endotracheal tubes (proper sizes!).

(b) **In-Patient:** The patient is prepared for procedure by parents and visit of the anesthesiologist the night before the operation. (The patient is admitted afternoon preoperatively.) Appropriate history, physical and laboratory study are carried out as mentioned earlier. Patient is medicated with opiate and atropine one hour preoperatively and barbiturate two hours preoperative and induced in one of the following ways:

1. Avertin® or pentothal rectally, open drop vinethene®-ether sequence and intubated. Oral intubation is used mostly and especially on younger age group (below 8 years). For those eight years and above and history of tonsillectomy, one may use nasal intubation. The oral

route is preferred because adenoids may produce profuse hemorrhage as a result of nasal intubation.

2. Avertin® or pentothal rectally, intravenous started and curare or curare-like agents, injected intravenously, vocal cords visualized, sprayed with cocaine or pontocaine® and intubated. Patient maintained on curare agents and nitrous oxide and oxygen. This is a non-explosive mixture, but proper fire and explosion precautions should always be observed.

3. **Intubation Technics:**

a. **Ayre's Tube:** (No rebreathing).[3] Ayre devised an effective open technic originally for cleft lip and palate operations which has since become widely used for operations around head and elsewhere. The apparatus consists of a T-tube inserted in the gas feed line close to the angle piece of the endotracheal tube.

On inhalation, the patient draws in gases from the anesthetic feed line and some air from the open arm of the T-tube. On exhalation, the exhaled gases pass out of the open arm. Artificial respiration can be carried out easily by intermittent closure with the finger at the open arm of the T-tube. This apparatus is a model of simplicity. It provides minimal resistance to respiration with efficient carbon dioxide elimination and adequate oxygen supply.

4. **Advantages of No Rebreathing Technic:**[4]

a. Provides unobstructed airway preventing blood and mucous from entering trachea and permits operator to work comfortably and easily.

b. Provides adequate carbon dioxide elimination with resultant quiet respirations.

c. It causes rapid removal of nitrogen from the lungs allowing higher alveolar concentration of the weaker anesthetic agents and oxygen.

d. Dissipates excessive heat from lungs helping to prevent a rise in body temperature.

5. **Complications of Intubation:**

a. Accidental removal of teeth, combination of rough laryngoscopy with loose teeth.

b. Hemorrhage:

1. Oral: Lips may get caught between the teeth and the blade, cutting the lip.

2. Nasal: Profuse hemorrhage may occur in the nose, especially if adenoids are present. Well lubricated tubes and careful insertion tend to minimize this complication.

c. Laryngitis: A mild laryngitis frequently occurs for one hour or so following extubation and is usually due to the use of too large an endotracheal tube. On occasion, tracheotomy may have to be resorted to.

d. Obstructed Tubes:

1. Obstructed lumen: old blood; keep stylets in always.

2. Kinked tubes: Rubber tubes soften with continued usage and age and lead to kinking at the angle of the mouth and/or posterior pharynx. Patient may bite on tube during light plane of anesthesia, obstructing his airway.

e. Improper Length of Tubes: Too long a tube may pass into one of the bronchi and cause atelectasis of the opposite lung.

GENERAL COMPLICATIONS

When one compares the complications of anesthesia in pediatrics to those of anesthesia for adults, it is apparent that there is a similarity in nature of complications, but a marked difference in the rate and time of incidence.

Hypoxia is the greatest single danger in anesthesia in pediatrics as it is with adults, but evidence is given that the effects are manifested more quickly. Apnea, shock and pulmonary edema will occur rather than such delayed effects as hypostatic pneumonia or atelectasis.

The induction period is frought with considerable danger because of the high nervous irritability and easily disturbed respiratory function of children. Inadequately premedicated children may continue to have irregular, gasping respiration throughout an operation if the induction period was filled with screams and loquaciousness. Also, poorly medicated patients are more prone to vomit during induction. Thus, premedication proves to be of considerable importance. A poor airway is undoubtedly the cause of most anesthetic complications.

In children, the tongue falls back against the roof of the mouth easily and prevents adequate aeration. Aspiration of vomitus will immediately occlude larynx and trachea and may give rise to generalized broncho-constriction and immediate death.

In children under anesthesia, circulatory disturbances are less frequently encountered than respiratory abnormalities. Occasionally an acute tachycardia will occur, but this usually responds to vagal stimulation.

In general, it may be said that infants and children will go safely through extensive operative procedures, if provided with adequate fluids and oxygenation. Deprived of either of these, the respiratory and circulatory balance will be upset quickly. Adequate measures must be instituted and the act of resuscitation well understood.

For sudden cessation of respiration or circulation, endotracheal intubation, positive pressure resuscitation and cardiac massage should be instituted immediately, fluids coming next; finally, if at all, one should think of administration of suitable stimulants in small, accurately gauged doses.[5]

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Hyaluronidase as an Adjunct to Pudendal Block In Obstetrical Deliveries

FRANKLIN C. HUGENBERGER, M. D.

THE advantages of local anesthesia in obstetrics have interested us since, as a resident obstetrician, we were depressed by the loss of parturient patients who, having been admitted in labor and with food in the stomach, were delivered under a general anesthetic. Vomiting was the frequent consequence, and a fatal pneumonia occasionally the sequel to inhalation of the vomitus.

Several years ago we found it necessary to use local anesthesia in delivery of three consecutive patients for whom a general anesthetic was undesirable. Two had mild cardiac disease and the third was suffering from pulmonary tuberculosis. Although in one case a Scanzoni rotation was required, and in another a midforceps procedure, results were so satisfactory that we decided on routine use of local anesthetics in deliveries, thus obviating the risks of inhalation anesthesia. Since then we have employed pudenal block in 3,000 patients, in most cases using only procaine as the anesthetic agent.

When hyaluronidase, the "spreading factor," became commercially available we investigated the possibilities of this enzyme as an adjunct to local anesthetic agents for still further improvement in the management of deliveries. In 75 patients analgesia was produced by infiltrating a mixture of procaine supplemented with hyaluronidase[1] into the pudendal area. Careful observation and evaluation of the results convinced us of the greater efficiency of this procedure, and we continued the method in 275 additional cases.[2]

TECHNIC

Usually the patient, having received obstetrical analgesia, is well under sedation on arrival at the delivery room. Tuinal® is generally used for primiparas, and seconal® for multiparas, in dosage of 4½ grains; demerol®, 100 mg., and scopolamine, 1/100 grain, are also administered. In prolonged labor, when an additional analgesic effect is required, doses of 50 mg. demerol® and 1/200 grain scopolamine may be repeated as necessary.

When ready for delivery the patient is draped and pudendal block carried out immediately, as follows: A total of 30 to 45 cc. of 1 or 2 per cent procaine is used for the procedure. Wydase,* 150 turbidity-reducing units, is dissolved in 2 cc. of the procaine, which is then mixed with the remainder of the anesthetic solution.

Using a 3½ inch, 22 gauge needle, which is introduced just medial to the tuberosity of the ischium, the anesthetic solution is infiltrated as the needle is advanced toward the ischial tuberosity. Then, from the same point of insertion, the needle is redirected anteriorly along the pubic ramus, with further infiltration of the solution. This procedure is repeated on the opposite side. In many cases, for a median or mediolateral episiotomy the anesthetic solution is also infiltrated locally at the desired site.

Addition of hyaluronidase to the anesthetic accelerates onset of anesthesia, which develops very promptly after injection and usually continues throughout repair of the episiotomy. If necessary to prolong analgesia, when the repair is unusually protracted, an additional amount of the anesthetic mixture may be injected into the edges of the episiotomy.

No other anesthetic is required, except occasionally for an unusually restless patient who will not lie quietly on the table, or when there is likelihood of precipitate delivery before draping and preparation can be completed. In such instances a small amount of ether may be administered by the open drop method, or nitrous oxide administered.

RESULTS

Patients who have received only the routine sedation during labor, and have been delivered under pudendal block analgesia supplemented with hyaluronidase, as described, are frequently conscious after delivery or are only slightly drowsy and easily awakened. On return from the delivery room many are able to transfer themselves without assistance from the litter to the bed.

A rare patient has experienced nausea and

Submitted May 27, 1953.

1. Alidase,® furnished by G. D. Searle & Co.
2. Wydase,® furnished by Wyeth.

* Wydase,® a highly purified, frozen-dried, testicular hyaluronidase, was supplied by Wyeth, Philadelphia. A turbidity-reducing unit is defined as the amount of hyaluronidase which will reduce the turbidity produced by 0.2 mg. of potassium hyaluronate in acidified horse serum to that produced by 0.1 mg. under assay conditions.

The Author

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vomiting, so common after general anesthesia; hence there is less danger of inhalation of vomitus.

There is no fall in blood pressure, as from spinal anesthesia; nor is there any risk of anesthetic shock.

Since there is no interference with normal uterine contractility, there is less danger of postpartum bleeding.

Although in the infant some effect may occur from the sedation of the mother, there is no additional depressant action, as from general anesthesia, which commonly produces narcosis and delayed respirations.

By mixing hyaluronidase with the local anesthetic agent, nerve block in the pudendal region becomes a much simpler procedure, especially for the inexperienced obstetrician, since the spreading action of the enzyme renders unnecessary an accurate and consistent deposit of the anesthetic solution along the nerve trunk.

For patients who desire obstetrical management by the Read method, with little or no analgesia during labor and delivery, the pudendal block is ideal. The technic may be employed for spontaneous, low or midforceps delivery, manual, or Scanzoni rotation; and repair of episiotomy or laceration, including third degree.

Breech delivery also may be readily accomplished, with the aid of the uterine contractions, which function normally to expel the contents of the uterus, unimpeded by the local anesthetic. At times, if the patient is sufficiently under analgesia, even a frank breech presentation may be converted to a double footling. (Version, however, should not be attempted without general anesthesia.)

Pudendal block, supplemented with hyaluronidase for more rapid dispersion of the anesthetic solution and more immediate onset of local analgesia, has proved eminently satisfactory for deliveries, so that at present we do not contemplate use of any other technic, such as caudal, low spinal, intravenous or inhalation anesthesia.

We have seen no evidence of sensitivity to procaine in any of the 3,000 patients delivered under pudendal block, or to hyaluronidase in the 350 patients for whom the procaine-hyaluronidase mixture was used. Local anesthesia does not predispose to infection for only one episiotomy broke open to a depth of 2 centimeters.

SUMMARY

Having found pudendal block satisfactory for obstetrical analgesia in 3,000 cases, the author sought to improve the technic by adding 150 turbidity-reducing units of hyaluronidase to the local anesthetic (procaine, 30 to 45 cc.) for greater dispersion and more rapid onset of analgesia. This method, employed in 350 cases, is eminently successful in spontaneous, low or midforceps delivery, Scanzoni rotation, breech delivery, and perineal repair.

Analgesia is prompt and of sufficient duration for normal deliveries; produces complete relaxation without interfering with the cooperation of the patient; is nontoxic for mother and infant; does not lead to postpartum bleeding, vomiting, infection, and other complications; and is so simple that it may be used in home deliveries.

There were no signs of sensitivity either to the procaine or the hyaluronidase.

KEEPING UP WITH MEDICINE

• CERES, the mythical goddess of the harvest, was pictured by the Greeks as giving the first grain to man. Hence the name *cereal.*

* * *

• HIPPOCRATES, about 400 B. C., forecast uses of our Basal Metabolic Determination: "Growing bodies have the most inate heat; they therefore require the most food, for otherwise their bodies waste. In old people the heat is feeble and they require little fuel, as it were, to the flame for it would be extinguished with much."

* * *

• IN GREECE, at about 400 B. C., Hippocrates linked the development of medicine to that of nutrition.

* * *

• GALEN (A. D. 130-200), as the result of experiments upon hogs, concluded that the stomach was a place in which food could be resolved into particles small enough to be absorbed.

* * *

• IN THE 18th Century, Lavosier became interested in the study of metabolism and tried to find out what became of food after it was digested. Then came the works of Liebig, Voit, Rubner, and Pasteur.

* * *

• EARLY IN THE 20th Century research workers demonstrated the need for good quality protein for the growth of animals. Then followed in rapid succession information as to essential minerals—major and minor, accessory food factors, essential fatty acids, hormones, enzymes, chemical regulators, and the intermediary products of metabolism.

* * *

• THE MOST common dietary error among adults, especially our women, is to watch calories without considering whether the calories they choose are in good company.

* * *

• AS ONE GROWS older the metabolism is reduced and total intake of 1200 calories in some instances may be sufficient. This makes the proper choice of foods all the more difficult. Here is where most of the dietary mistakes are made. —J. F.

Intramuscular Typhoid in Various Eye Conditions

ROBERT S. ROSNER, M. D.

WITH the present severe shortage of hospital beds, any method of therapy that is effective and can be safely used outside the hospital merits consideration. This is an office method of administering killed typhoid bacterial vaccine intramuscularly. It is a method that was born out of desperation while waiting for a hospital bed with a patient rapidly going blind. I wish to emphasize that large doses of killed typhoid bacterial vaccine given intramuscularly is remarkably effective and safe.

METHOD OF ADMINISTRATION

I use typhoid-paratyphoid vaccine manufactured by Parke, Davis & Co. This vaccine contains per cc.:

Salmonella typhosa (B. typhosus) ..... 1000 million
Salmonella paratyphi (B. paratyphosus A) ..... 250 million
Salmonella schottmuelleri (B. paratyphosus B) ..... 250 million

The injection is given intramuscularly in the deltoid or in the buttock. A sterile syringe is used and the skin over the injection site is cleaned with alcohol. A very fine needle is used, Number 26 or 27, so that there is less likelihood of hitting a blood vessel. The container should be shaken to mix the vaccine and the vaccine drawn immediately into the syringe and injected into the chosen area. A different site should be picked for the next injection.

The average beginning dose may be .3 to .5 cc. The size of subsequent doses must be determined by the reaction to the last dose; ordinarily it may be increased by ½ cc. until 1½ cc. are given. I have used as high as 3 cc. with no untoward effect. In older patients one may begin with .1 cc. or .2 cc. Injections may be given daily in desperate cases, less frequently in other cases, i. e. two times per week.

TYPES OF REACTION

The patient usually reports having a headache; many patients state that they experienced a fever that began three hours after the injection. There is an advantage in the time lag, since patients are home long before the reaction begins. Some persons get a chill. Some get no reaction except a soreness at the site of injection. Some patients complain of joint soreness, others of "stiff neck." The soreness at the site of injection can be rather painful. If the injections are given over a prolonged period in the thigh or buttocks, the lymph nodes in the groin may enlarge.

In three cases eosinophil counts were done recently. The Thorn test was employed to see what effect the injections had. In each there was a marked fall in eosinophil count.

Submitted June 25, 1953.

The Author

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RESULTS OF INTRAMUSCULAR TYPHOID—PARATYPHOID VACCINE IN 79 CASES OF OCULAR DISEASE

Types	Number	Improved	Relapses	Comment
Scleritis & Episcleritis	5	4	1	
Severe corneal ulcer (indolent)	3	3		One patient required hospitalization with electrical cauterization and covering with conjunctival flap. She recovered.
Deep keratitis, etiology unknown	2	2		
Luetic keratitis including keratoiritis	5	5		Results here were rapid and dramatic.
Anterior uveitis	26	23	3	Mostly before cortisone was available.
Posterior uveitis and choroiditis	18	13	5	Cortisone given orally didn't seem to alter the effect when used together.
Optic neuritis and retrobullar neuritis	14	11	3	
Sympathetic ophthalmia	1	1		Required two years of active treatment. Patient has recovered.
Uveitis—Secondary glaucoma	5	3	2	

SUMMARY

Intramuscular typhoid-paratyphoid vaccine has the following definite advantages:

(1) Effective and inexpensive to the patient.

(2) Safer than intravenous vaccine in older or in sickly patients.

(3) Prevents loss of valuable time while waiting for a hospital bed.

(4) It can be used with cortisone either locally or systemically.

(5) It works in many cases where cortisone used alone appears to have failed.

(6) It may be used for a long period of time if necessary.

(7) The patient can stay on his job while under this form of treatment.

(8) It is especially good in tuberculosis, and luetic iritis where cortisone systemically is undesirable.

Palliation in Incurable Carcinoma of the Female Pelvis

PAUL R. ZEIT, M. D.

The Author

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IN the management of the patient faced with ultimate death from an incurable disease, the philosophy and moral beliefs of the physician or group of physicians charged with such management inevitably influence the course of treatment followed. In this paper philosophical argument will be studiously avoided and such questions as euthanasia and withholding of blood or antibiotics are intentionally omitted in favor of the presentation of positive measures for symptomatic relief in these women suffering from an incurable malignant tumor in the pelvis.

The responsibilities of the physician begin with the establishment beyond reasonable doubt that the carcinoma is truly incurable. Obviously, any medically sound chance for cure must be followed to completion before purely palliative measures are instituted. Clinical judgment and experience are invaluable in making this decision, but even to the seasoned practitioner it may be one of the most difficult decisions in the practice of medicine. However, once the physician has decided to abandon active therapeutic measures, he is faced with two very clear-cut responsibilities.

The patient is of first importance always. All palliation should have as its objective an increase in the over-all comfort of the patient. The discomfort of radiation sickness should be very carefully weighed against the possibility of relief of pain due to diminution in the size of a tumor mass. The unavoidable discomforts of surgical procedures, whether major or minor, must not outweigh improvement in the general well-being obtained by surgical intervention. However, the value of doing something, anything, for the complaints of a patient with incurable carcinoma should not be under-estimated.

The sustenance of hope in these patients is in itself a remarkably effective palliative measure. The patient will greatly benefit psychologically if some specific instructions can be left at each visit, even though they be only minor changes in diet.

The second responsibility is that to the patient's family. At least one member of the immediate family must be fully informed of the situation and the ensuing events as they occur. The relatives should be told in detail of the physical and mental needs of the patient and advised as to how these can be met with the least impairment of the financial and physical rights of the rest of the family.

PAIN

The most common and pressing problem to be solved in the management of patients under discussion is that of relief of pain. An intelligent effort to relieve pain must be based on a knowledge of the cause of pain in the specific patient. It is a most important, but frequently forgotten, fact that cancerous tissue is not painful in and of itself. Tumor masses of huge size can be entirely painless. Therefore, reduction in the size of a carcinomatous growth will not diminish pain unless there is pressure, tension, and/or obstruction caused by the bulk of the mass. Pain is always of secondary origin in pelvic malignancy.

COMMON CAUSES

Following is a discussion of the common causes of pain in their order of diminishing frequency:

1. **Secondary infection.** This is particularly common in the surface lesions, such as carcinoma of the cervix, vulva, and vagina, and these growths should always be regarded as infected. Endometrial neoplasms are not painful at their primary site unless associated with pyometra or uterine distension, and ovarian malignancy, because of its location, is seldom infected. In addition to infection of tumor tissue itself, the bacterial invasion of tissues or organs not directly involved by carcinoma, but made more susceptible to infection because of the tumor, must be constantly borne in mind. Cystitis, ureteritis, and pyelonephritis are common examples of this, occurring most frequently in conjunction with carcinoma of the cervix.

2. **Obstruction of a hollow viscus**—partial or complete. Outstanding in this group is the ureteral obstruction due to direct extension or metastic nodes of cervical carcinoma. Complete obstruction of the ureter ultimately leads to a cessation of urine output of the kidney from that side and physiologic painless death of the kidney, but the hydro-ureter and hydronephrosis preceding this end result can be extremely painful. Obstruction of the gastrointestinal tract or biliary tract by metastatic tumor is commonly a cause of upper abdominal pain.

3. **Bony metastases.** The skeletal system is frequently involved by metastatic lesions from carcinoma of the cervix and less commonly from carcinoma of the endometrium and ovary. The

Submitted October 23, 1953.

pelvic girdle is affected more commonly than other bones of the body and this both by direct extension from the primary lesion and discrete metastases. Lesions in the bone are almost always painful, probably because of tension on the periosteum. The statement made earlier that carcinoma is not painful in itself holds for these bony lesions as well as carcinoma at other sites.

4. **Tension and pressure.** Into this category fall tumors that cause pain because of their bulk. If tumor mass is intrinsic within an organ that is made painful, such as the liver or kidney, the pain is due to tension on the capsule of that organ. In other instances, the tumor mass may be extrinsic to the site of the pain, and here it is direct pressure against nerve, muscle, or other soft tissue which continually s'imulates the sensory nerve endings. Probably the most commonly seen tension pain occurs in bony metastases mentioned above, and perhaps almost as frequently in liver metastases. Pain due to direct pressure is almost always pelvic in origin and usualy occurs from pressure against the sciatic nerve in which case the pain distribution follows the course of that nerve.

5. Ascites perhaps should be called more a cause of discomfort than acute sharp pain, but the distress of a markedly distended abdomen cannot be neglected. It occurs very commonly with carcinoma of the ovary, particularly when there are associated wide peritoneal implants, and less frequently in association with carcinoma of the cervix or endometrium, and then probably only when there is portal obstruction due to liver metastases.

6. **Direct nerve involvement.** Nerve trunks are peculiarly resistant to invasion by malignant tissue and most nerve pain in the patients under discussion will be due to pressure rather than direct invasion of the nerve. However, the latter does occasionally occur, and in the living patient it is impossible to differentiate between the two. They should perhaps be discussed together since their differentiation is a purely academic point that can be settled only on the autopsy table.

7. **Hemorrhage.** Bleeding in itself is not a cause of pain unless the escaped blood is confined to tissue spaces or body cavities such as the abdomen or pleural space. Pain due to hemorrhage is only infrequently seen and as a rule cannot be differentiated from ordinary ascites or hydrothorax until the body cavity is tapped to drain off fluid.

8. **Decubiti.** Decubitus ulcers are a late but very common occurrence, and their role in the suffering of a terminal carcinoma patient is obvious even to the most casual observer.

In general, the practical methods of relieving pain in incurable carcinoma of the female pelvis may be divided into several categories. These are: specific medications, surgical procedures, radiologic techniques, general supportive measures, and endocrine therapy, in the order of their usefulness.

SPECIFIC MEDICATIONS

The specific medications are by far the most widely used and the most readily available of the effective palliative measures. Such analgesics as the salicylates and phenacetin® have little, if any undesirable side effects and can be used alone or in combination with other more powerful drugs for long periods of time with great benefit. Often the combination of salicylates and a sedative, such as a barbiturate or chloral can appreciably forestall the inevitable necessity of resorting to the habit forming narcotics.

It is true that in patients whose outlook is hopeless, the fear and dread of addiction to morphine or its derivatives is not a paramount problem, but the chain of events leading to steadily increasing doses of narcotics because of the tolerance of the individual is best delayed as long as possible and compatible with the comfort of the patient. Almost inevitably codeine, then morphine, demerol,® dilaudid,® pantopon,® or one of the other morphine substitutes, must be restorted to and the course of medication from this point on is only too well known.

Several other medications that are worthy of mention are procaine administered intravenously, snake venom, and alcohol given either orally or intravenously. Each of these has had its wave of popularity, but the results from their use have at best been undependable and the consensus is that they are of little practical value.

The surgical procedures that are available deserve a more detailed discussion. They are not used as frequently as the narcotics and analgesics because the relief derived from them is less certain, their execution requires more skill, and they all involve some discomfort in themselves to the patient, which must be carefully balanced against the hope of achieving relief of pain. In general, it should be accepted as a prerequisite to the use of these measures that the patient have a life expectancy of six months or more. This in itself markedly reduces the number of patients for whom these techniques should be considered.

CAUDAL ANESTHESIA

The simplest and least traumatic of the surgical approaches is the production of a caudal anesthesia by the extradural administration of an anesthetic agent in an oil vehicle. This can be done without hospitalization and when carried out properly, results in no motor paralysis. It is particularly effective for pain in the perineum and lower extremities and the duration of anesthesia is anywhere from a few days to several months. The technique of administration has been adequately described by Kenny in the

British Medical Journal, November 29, 1947, page 862.

At University Hospitals of Cleveland we have used zylcaine® in peanut oil as a caudal anesthetic on over 20 patients with good results in about 50 per cent. In three patients there was transient incontinence of urine and feces with complete control regained in less than 24 hours. In two patients there was a transient partial paralysis of the lower extremities which disappeared within 48 hours.

One point that was made particularly plain in this small series of cases is a fact that applies equally well to any surgical approach to the relief of pain. That is, that those patients who are already addicted to the use of narcotics will get little or no relief in spite of good anesthesia as determined by the usual methods of testing surface and deep anesthesia. In other words, a surgical attempt to relieve pain should be made before the patient has had a prolonged program of narcotics.

SUBARACHNOID ALCOHOL INJECTION

Another procedure which is relatively simple is the subarachnoid injection of absolute or 95 per cent alcohol done as in an ordinary lumbar puncture. The alcohol injected into the subarachnoid space has a lower specific gravity than spinal fluid and rises to the top of the fluid column. Thus, with the patient placed on the side contralateral to the most severe pain, and lying slightly forward on the abdomen, it is hoped to affect only the posterior roots just before they enter the cord. There is some increase of pain for a few minutes after injection, but in a short time relatively complete anesthesia is obtained.

The risk of involving the anterior motor roots is always present and the positioning of the patient is extremely important. This subarachnoid use of alcohol gives a more prolonged effect than the caudal anesthesia but is less certain and complete in its results. Obviously, a single injection will affect only one side of the patient and if the pain is distributed over both sides, two separate injections must be made.

PARAVERTEBRAL BLOCK

A third approach to pain relief which can be done on an ambulatory basis is the paravertebral block. This, of course, gives relief of pain in only a very restricted area, but it involves less risk to the patient than either the subarachnoid alcohol or the caudal anesthesia. The injection may be made with procaine or one of its derivatives first to determine the degree of relief that can be obtained and then, if indicated, repeated, using an anesthetic agent in oil or alcohol for a more lasting effect.

MAJOR SURGICAL PROCEDURES

The remainder of the surgical approaches are in the realm of major surgery requiring hospitalization and involving a great deal of inherent discomfort in the surgical approach itself. The first of these is posterior root section in which the posterior roots themselves are completely severed after they pass through the dura from the cord. This results in a very restricted area of anesthesia and too often adhesions and scar tissue around the proximal stump of the severed root will cause as much pain as was present in the first place.

More satisfactory and perhaps one of the most frequently used of the surgical procedures is that of chordotomy. This involves severing the contralateral spinothalamic tract in the lower or mid thoracic region. When expertly done, it gives good relief of pain, but the technical difficulties involved in the operation are not inconsiderable. The pyramidal tracts run in apposition to the spinothalamic tracts and are sometimes injured during the course of operation, resulting in a temporary weakness of the muscles of the lower extremity on the side of operation. In addition, incontinence of urine not infrequently results and these patients who have had a chordotomy seem much more prone to develop decubiti. However, the relief of pain achieved by this method is permanent and it is especially useful in those patients who have a relatively long life expectancy.

The operation of pelvic exenteration or the Brunschwig-Schauta operation is one which in occasional instances is done with the hope of effecting a complete cure. For this reason it is not a strictly palliative procedure, but in the great majority of instances in which it is performed it can be considered as such. There have been a number of excellent papers published about this heroic operation in the past few years, but certainly the average surgeon is not qualified to perform it and the limited number of patients to which it is applicable makes it almost a rarity to be seen only in the large cancer treatment centers. Such a radical surgical approach is still in the experimental stage, and its place in the treatment of advanced pelvic cancer is at present uncertain.

There are yet two other operations which should be mentioned for the sake of completeness, namely, prefrontal lobectomy and presacral neurectomy. The former is a procedure by which the patient's appreciation of pain is so altered that she is able to live with constant pain and yet not require any relief. This operation often produces drastic personality changes which almost put it in the realm of experimental medicine.

The latter, presacral neurectomy, is an operation which is worth while carrying out only if the lower abdomen must be entered for some other reason. There is good evidence to support the idea that deep pelvic pain may be relieved by resection of the sympathetic fibers of the superior hypogastric plexus. It can be simply done once

the location of these ganglia is exposed, but the relief of pain from it is neither certain enough nor complete enough to warrant doing a laparotomy for that purpose alone.

RADIOLOGICAL TECHNIQUES

The radiological approach to pain relief is pretty well limited to those patients with bulky tumors where the pain is due to compression or tension, those with bone metastases or patients with ascites or hydrothorax. In addition, the occasional patient with an ulcerated superficial lesion with pain due to secondary infection, may benefit from low dosage superficial therapy which will help in the control of local infection and may occasionally bring about the healing over of raw ulcers.

In general, the local application of radium, radon, or radioactive isotopes have little place in the field of palliation. However, there is one notable exception to this rule and that is the use of a colloidal gold suspension to treat the rapid production of ascitic fluid or fluid in the pleural space. The element AU198 forms a stable colloidal suspension and because of its short half-life, is a safe means of administering moderately large doses of radiation to the lining of the peritoneal cavity and pleural cavity. After the administeration of 100 to 150 millicuries of gold in several hundred cubic centimeters of saline into the abdominal cavity, patients who have required paracentesis up to several times a week, may go for several months without a recurrence of their ascites. Systemic disturbances, such as nausea, are minimal and installation is easily done through an ordinary paracentesis trocar.

Our experience with this technique at the University Hospitals of Cleveland in the department of radiology has given good results in eight patients treated. In these patients the dose ranged up to 150 millicuries and in none of the patients was there any serious complication encountered. In all patients there was a very marked diminution in the rate of formation of ascitic fluid, and in several of the patients, repeated gold installations were done without difficulty or untoward effects.

The use of external x-ray therapy through the usual four to six pelvic fields or the use of vaginal cone therapy to reduce the size of an intrapelvic mass is of considerably limited value. Most of these patients have been heavily irradiated before and they will not tolerate the doses required without severe irradiation sickness and permanent damage to the normal tissues in the pelvis.

GENERAL SUPPORTIVE MEASURES

General supportive measures available to every physician can actually be a major means of palliation. Antibiotics, whole blood, proper nutrition, rest, and perhaps above all, psychic encouragement and help can do more than all of these specific attacks that have been mentioned. It should be unnecessary to point out that a patient with an incurable carcinoma is just as much a whole person as any other patient, and to palliate a local tumor is entirely inadequate if the rest of the patient is neglected.

ENDOCRINE AND CHEMO-THERAPY

Still another possible means of relieving pain in these patients lies in the field of endocrine and chemo-therapy. Unlike the use of the male and female hormones in carcinoma of the breast and carcinoma of the prostate respectively, the use of endocrines in palliation of carcinoma of the cervix is not an accepted procedure. However, a great deal of work is being carried on at the present time at a number of different institutions in the United States which has given encouraging preliminary results with the use of massive doses of progesterone to relieve pain and reduce the size of intrapelvic tumor masses.

The use of antifolic acid compounds, such as teropterin® or aminopterin,® has given uniformly discouraging results. Recently the use of intra-arterial nitrogen mustard and related compounds has given some encouraging results, but their use is still considered experimental. In a very limited experience at University Hospitals, we feel hopeful that the nitrogen mustards may be of value to relieve pain and reduce the size of a tumor mass.

HEMORRHAGE

Massive external bleeding from carcinoma of the cervix is a not infrequent occurrence in the late stages of the disease, and often presents the physician with an acute situation. The use of pure acetone applied directly to the cervix is the quickest and most reliable method of controlling surface bleeding. It is a time-honored technique that is often neglected in present day teaching. The only materials necessary are a tubular speculum and the acetone. The speculum is inserted to the full depth of the vagina to protect the mucosa of the vulva and lower vagina, and acetone can then be poured into the speculum or soaked pledgets of cotton can be inserted against the bleeding cervix. This can be done without anesthesia and in the home.

The acetone should be left in contact with the cervix for at least 15 minutes and if bleeding is extremely profuse, should be replaced frequently during this time. We have not yet seen this method fail to control the bleeding except when the bleeding is from a major cervical artery. After the bleeding has stopped or has been reduced to a reasonable minimum, the excess acetone should be carefully sponged out and the vagina tightly packed.

If these measures fail to control bleeding, then it is necessary to resort to ligature of the

uterine vessels from the vaginal approach or if time and condition of the patient warrant, the ligation of the ovarian and internal iliac arteries from the abdominal approach.

Frequently the bleeding from a late cervical carcinoma will not be profuse enough to be alarming from the point of view of blood loss and shock, but extremely irritating to the patient because of the necessity of constantly wearing a perineal pad. This type of slow ooze can frequently be controlled by low dosage vaginal cone x-ray which will produce enough obliterative endarteritis and healing of the surface of the carcinoma to completely stop the bleeding. It must be made certain, however, that the oozing is not from a secondarily infected radiation necrosis, in which case additional x-ray therapy will only aggravate the situation.

FISTULAS

The fistulas that occur so commonly in vaginal and cervical carcinoma are an extreme source of discomfort to the patient and present a very difficult problem to the physician. The recto-vaginal fistulas can, if they are small, sometimes be controlled and made bearable with diet alone, or a combination of diet and paregoric, keeping the patient slightly constipated.

Vesicovaginal and ureterovaginal fistulas are much more difficult to handle, and control by some mechanical device to either obstruct the fistulous tract or to collect urine in the vagina is usually necessary. A Foley bag catheter can sometimes be passed through the opening from vagina into bladder and the inflated bag within the bladder may be adequate to obstruct the flow of urine through the opening in the vesico-vaginal septum. If the communication is right at the urethrovesicle junction, a Foley bag inserted through the urethra may position itself in the fistulous tract so that flow into the vagina is obstructed. More often than not, however, these devices with a Foley bag are not successful.

Occasionally a contraceptive diaphragm can be fitted to the patient with a hole cut in the center of it through which is inserted a mushroom catheter. The mushroom can then be cemeted to the diaphram, and in this way collect urine in the vagina which can then be released by unclamping the catheter at convenient intervals.

In older women with an extremely small vaginal orifice, a 25 to 50 cc. Foley bag can sometimes be inflated in the vagina to a point where the perineal floor supports it and retains it in the vagina. In this case the vagina itself functions in a manner similar to the catheterized bladder. In addition to these home-made devices, there are numerous commercial rubber attachments held on by belts and straps, which are attached over the vulva to collect the urine after it has drained from the vagina.

Surgical correction of rectovaginal and vesico-vaginal fistulas in these patients is almost never to be considered. Local surgical measures should not be attempted until at least six months and preferably one year after the last radiation has been given and only in those individuals showing no residual carcinoma by biopsy. There are very few patients in whom palliative measures only are indicated that will live long enough to consider such steps. Transplantation of ureters into bowel is another surgical measure that may be useful in patients with a long life expectancy.

A word about the prevention of fistulas, particularly with regard to palliative radiation, should be very seriously borne in mind. Palliation by vaginal cone x-ray or the local application of any radioactive element should not be attempted until it is absolutely certain that the vaginal lesions are carcinoma and not radiation necrosis. Very frequently it is difficult to distinguish between the necrotic cavity of an endophytic carcinoma and the degeneration produced by over-irradiation. Obviously, in the latter instance, further irradiation will be very likely to lead to the development of fistulas, so that biopsy of such craters should always be performed before the course of therapy is decided upon. Nursing care and general hygienic measures are of utmost importance in the management of genital fistulas.

SUMMARY

The palliative treatment of the woman with incurable carcinoma of the pelvis is discussed with particular reference to the management of pain, hemorrhage, and fistulas. The necessity of treating the whole patient as a person has been stressed along with specific measures to manage each of the three problems mentioned. The causes of pain have been listed as secondary infection, obstruction of a hollow viscus, bony metastases, tension and pressure, ascites, direct nerve involvement, hemorrhage, and decubiti.

The various methods of relieving pain have been discussed under the headings of specific medications, surgical procedures, radiologic techniques, general supportive measures, and endocrine and chemo-therapy. The indications, contraindications, and usefulness of each of these therapeutic measures has been discussed with an attempt to point out specific situations in which each may be of benefit.

Neurosyphilis Activated by Trauma

Trumpeer states "it is fair to conclude that a given injury to the head in a non paretic syphilitic is responsible for the paretic signs which follow" and medicolegal reports published in the *Journal of the American Medical Association* in 1928, 1931, 1933 and 1937 show compensation awards for activation of syphilis by industrial trauma. — Sidney Vernon, M. D., Willimantic, Conn., and Wm. H. Davis, M. D., Los Angeles; *Connecticut State M. J.*, 18:124, February, 1954.

Infrequent Type of Primary Carcinoma of the Liver—Report of Case

PETER H. MULDER, M. D.

THE occurrence of primary carcinoma of the liver is reputed to be infrequent. Charache[1] of Brooklyn, in 1937, in reviewing a series of 151,762 autopsies in 31 institutions found the incidence to be 0.506 per cent. McNamara[2] and associates in Illinois, in 5,200 autopsies found 34 cases with primary carcinoma of the liver, or an occurrence of 0.629 per cent.

Furthermore, the absence of cirrhosis in a primary hepatic carcinoma is also very uncommon, reported to be variously found in from zero to 15 per cent of all cases of primary hepatoma. Moreover, McNamara et. al. point out that the type of primary hepatic carcinoma that they identify as multiple malignant hemorrhagic hepatomata is likewise rare. They found only two cases of this type among the 34 cases of primary hepatic carcinoma. Therefore, the following case is felt to be of some interest.

ANAMNESIS

The patient, a 62 year old farmer, was admitted to the Wayne Hospital, Greenville, Ohio, on March 28, 1951, with the chief complaint of "soreness" in the right upper abdominal quadrant.

The present illness began 10 days before admission. It had begun suddenly with a sharp evanescent pain in the right upper quadrant, when the patient turned over while lying in bed. This pain was followed by a more constant, dull soreness in the region of the right upper quadrant and right flank. He attributed his complaint to having moved some baled hay three days prior to onset of symptoms, and assumed that he had "pulled a muscle." Further history by systems was negative except for nausea and vomiting which occurred on the day of admission to the hospital.

Past history was negative except that some five or six weeks previous to admission, the patient had noted one occurrence of bright blood in the stool. Since then, on several occasions, his stools were said to have been tarry in color. He estimated that in the past two weeks he had lost approximately 12 pounds in weight, but insisted that his appetite had remained good and that he had no definite food idiosyncrasy.

Family history showed that both parents had died in the seventh decade, the exact cause of death being unknown. One sister died of cancer of the uterus in middle age, and a daughter died at age 9, of a "cancer of the bowel and a cancer of the urinary bladder." Six children are living and well.

PHYSICAL EXAMINATION

On admission to the hospital the patient appeared to be in no acute distress. He was well developed and well nourished; however, the skin appeared sallow and pale, and tissue turgor was poor. Temperature was 100° F.; blood pressure 158/90; pulse 80, regular, and of good quality; respirations 20. The remainder of the physical examination was essentially normal except for the abdomen which appeared to be rather obese and full but soft. There was in the right upper quadrant a mass which presented in the midclavicular line as a tender solid mass which on inspiration, extended 12 cm. below the costal margin and approximately 6 cm. in transverse diameter. The spleen was not palpably enlarged. Rectal and sigmoidoscopic examinations showed no abnormalities. Admission diagnosis was subacute cholecystitis or hydrops of the gallbladder.

Submitted August 14, 1953.

The Author

● Dr. Mulder, Arcanum, Ohio, is a member of the medical staff of Wayne Hospital at Greenville.

COURSE IN THE HOSPITAL

Admission laboratory studies showed a blood count as follows: Hemoglobin: 59 per cent, or 7.8 gms.; red blood count: 3,450,000 per cu. mm.; white blood count: 15,050 per cu. mm.; polymorphonuclear leukocytes: 90 per cent; stab forms: 16 per cent; small lymphocytes: 10 per cent. The sedimentation rate was 11-22-27-29 mm. in 1 hour. The urinalysis was normal except for 1 plus albumin with occasional granular casts. A Mazzini test was negative. The fasting blood sugar was 137 mg. per 100 ml.; and the non-protein nitrogen was 69.5 mg. per 100 ml. A stool specimen while the patient was on a meat free diet was markedly positive for occult blood and appeared black in color.

An electrocardiogram was within normal limits.

Posterior-anterior film of the chest was normal, however the right dome of the diaphragm was reported to be somewhat elevated.

Gallbladder visualization was attempted but the patient did not retain the dye.

Radiography of the large bowel showed "the colon was outlined completely showing considerable redundancy throughout with no evidence of defects around to the cecal area which appeared to lie rather high in the right side of the abdomen with some foreshortening of the ascending colon. There appeared to be a definite spill over into the small bowel which was not particularly unusual but the cecal cap never filled completely." The radiographic consultant expressed the opinion that "there must be a para-cecal abnormality such as an appendicecal abscess tending to deflect the cecum upward."

The upper gastrointestinal roentgenogram showed an essentially normal esophagus, stomach, duodenum, and small bowel.

The gallbladder study was then repeated, with heavy dosage of antispasmodic and sedative medication preceding the administration of the dye. Without vomiting or diarrhea, the patient's subsequent roentgenogram showed "a complete failure of visualization" and "no evidence of opaque calcification" in the gallbladder area.

An intravenous pyelogram was then performed

on the basis that retroperitoneal pathology may have deflected the cecum upward. A conclusion of non-functioning right kidney was made. A genito-urinary consultant, however, demonstrated by retrograde study that the right kidney pelvis and calices were normal in outline.

The patient's temperature continued to rise slowly to a peak of 102.8° F. and the white blood cell count rose to 18,000 per cu. mm. Total protein at this point was 6.4 mgm. per 100 ml. and the albumin/globulin ratio was 2.7/1.3.

On the 8th and 9th hospital days the patient mentioned a slight discomfort in the left upper quadrant of the abdomen but no abnormal physical signs were found. On the 11th hospital day, a decision to perform a laparotomy was made after surgical consultation, because in spite of all supportive treatment including two blood transfusions, and antibiotic therapy the patient's general condition was deteriorating. The temperature was septic with daily spikes from 99 to 102 degrees F.; the hemoglobin continued to fall to 45 per cent; the leukocytosis persisted, with a white blood cell count of 14,450 per cu. mm. of which 85 per cent were polymorphonuclear leukocytes; and icterus index rose to 22. On the night before the operation the patient complained of a marked accumulation of gas, the abdomen became markedly distended and tympanitic, and an ecchymosis was noted in the subcutaneous tissue about the umbilicus. An enema relieved the distention and the patient felt reasonably well the morning of the operation.

The **operative findings**, as recorded by the surgical consultant, were as follows: The peritoneal cavity contained approximately two quarts of grossly bloody fluid. The liver was markedly enlarged and contained numerous variable sized nodules. The anterior surface showed a massive tumor nodule which had apparently undergone necrotic change and was the site of active bleeding. The gallbladder was examined and found to be thin-walled, small in size, containing no stones. Because of excessive bleeding, the patient's poor condition, and the multiple adhesions about the liver surface, it was impossible further to explore the abdomen. An attempted biopsy was unsuccessful because of the fragility of the liver tissue and the marked hemorrhagic tendency.

Postoperatively, the patient had a stormy, progressively downhill course, and expired on the fourth postoperative day.

AUTOPSY FINDINGS

Autopsy examination, permission for which was limited to the abdomen, revealed these significant findings as reported by the pathologist-consultant. The skin was jaundiced grade 3. There was diffuse ecchymosis of the entire abdominal wall, particularly around the recent right upper quadrant incision. The peritoneal cavity contained 3000 cc. of brown fluid with multiple clots of blood. The omentum was adherent by recent and ancient fibrin adhesions, grade 2, to the anterior surface of the left lobe of the liver and the right diaphragm was adherent over a large area to the dorsal surface of the right lobe of the liver.

The liver margin was 12 cm. below the costal margin in the right mid-clavicular line and 8 cm. below the xiphoid. The diaphragm on the right arched to the 3rd rib and on the left to the 4th rib. The spleen was normal in size and consistency. The stomach, duodenum, jejunum, ileum, and colon were normal throughout. The appendix was completely retroperitoneal and retrocecal without evidence of inflammation.

The liver weighed approximately 5,000 grams and was increased approximately twice the normal volume. The capsular surface was studded with multiple confluent umbilicated nodules varying from 2.0 to 8.0 cm. in diameter, with multiple areas of rupture of the capsule and recent hemorrhage. The area of capsule between the nodules was yellow-green and the nodules were reddish-brown. The cut surface varied from a deep red-brown in the numerous nodular areas, to a grey-green in the non-tumorous areas.

The gallbladder showed no abnormalities. The ducts were not dilated, and there were no cholioliths. The pancreas and the pancreatic duct were normal. The kidneys, adrenals, ureters, bladder and prostate were normal.

The anatomical diagnosis was: Primary carcinoma of the liver (multiple malignant hemorrhagic hepatomata).

The microscopic diagnosis was: Primary hepatoma without cirrhosis.

COMMENT

It is interesting to note several features:

(1) Although this case showed far advanced involvement of the liver (see Fig. 1), the history



Fig. 1. Anterior Surface of Liver.

of illness was short, and the symptoms were mild, (findings that are repeatedly reported).

(2) The roentgenologic and autopsy finding of the high level of the right diaphragm is similar to the experience of Tull in Singapore as reported by Charache, who found 52 of 134 cases which showed the dome of the right diaphragm pushed into the thorax, some as far as the 3rd rib.

(3) The absence of biliary cirrhosis in this case is in agreement with McNamara's finding that neither of the two cases demonstrating multiple malignant hemorrhagic hepatomas in his series of 34 cases of primary carcinoma of the liver showed evidence of cirrhosis.

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Carcinoma of the Breast Without a Palpable Mass

A Review of Current Literature and Case Report

LEROY JAY HYMAN, M. D.

DESPITE the efforts made for educating both the clinician and patient in the early detection of breast cancer, late cases are still a common occurrence. To make it more difficult, there are patients, fortunately small in number, who have advanced carcinoma of the breast without a demonstrable breast lesion on palpation.

The usual sequence of events involves the discovery of an axillary node by the patient, which upon excision shows adenocarcinoma. Subsequent radical mastectomy then reveals the carcinoma of the breast. Current literature contains the reports of 14 such cases. The purpose of this paper is to review these cases by tabulation and to add a fifteenth.

CASE REPORT

A 45 year old white female was first seen in February, 1953. She had developed a nodule in the right axilla in April, 1952, which had not increased in size. However, at the patient's insistence, the node was excised by her family physician ten days prior to this first visit. The diagnosis, as reported by three pathologists, was lymph node with adenocarcinoma compatible with breast origin, but not distinctive.

Review of systems was non-contributory. Complete examination was within normal limits, with the exception of the right axilla, where there was a well healed, indurated, vertical incision. The right and left breast and left axilla contained no palpable masses. (This was the clinical impression of five examiners.) There was no evidence of disease of the right upper extremity, the skin, lungs or blood. No other lymphadenopathy was present. X-ray survey of the lungs, gastrointestinal tract and genito-urinary system failed to reveal any primary cancer.

The patient was operated upon March 2, 1953, at which time, a right radical mastectomy was done. Upon examination of the specimen, a hard mass, measuring about 2 cm., was felt in the tongue of the breast tissue extending towards the axilla. This was found to contain carcinoma. Six firm nodes were recovered from the axillary fat, two of which contained carcinoma. The patient made an uneventful recovery and since has received a course of x-ray irradiation.

Malignant cells are found in axillary nodes associated with cancer of the structures of the upper extremity, lungs, the lymphoblastoma group and generalized carcinomatosis. Excluding these possibilities, the finding of a unilateral axillary node containing adenocarcinoma means carcinoma of the breast. No case has been reported in which the mastectomy did not reveal the origin of the cancer, but careful examination by the pathologist is necessary.

Treatment consists of radical mastectomy with axillary lymph node dissection followed, usually, by irradiation. The prognosis so far for these cases does not seem to differ from those in which there is a palpable carcinoma of the breast with axillary involvement.

The Author

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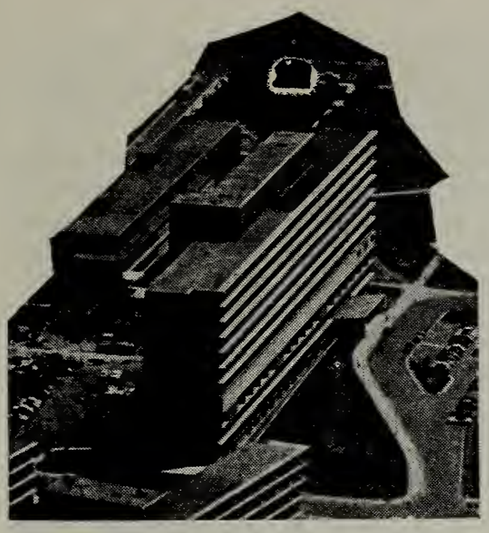
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TABULATED REVIEW OF CASES

Reported by	Case Number	Radical Mastectomy	Surgery plus Irradiation	Description Given of Size of Breast Primary	Clinical Manifestations of Breast Cancer in Non-operated Cases in years	Number of Additional Axillary Nodes Found with Cancer	Years living at time of report
Jackson	1	Yes	Yes (Preoperative Radium)	3 x 3 cm.	3 years	?	> 2
	2	Yes	Yes	"Minute"	—	several	> 4
	3	Yes	Yes	"Match-head"	—	1	> 2
Westemeyer	4 Thru 9 (6 cases)	3 cases	2 cases	?	?	?	?
Weinberger and Stetten	10	Yes	Yes	"Walnut"	—	2	> 13
	11	Yes	Yes	2 cm.	—	3	> 12
	12	Yes	No	1 cm.	—	none	> 5
	13	Yes	No	?	—	none	> 3
	14	Yes	No	?	—	none	> 2
Hyman	15	Yes	Yes	2 cm.	—	2	< 1

Submitted July 14, 1953.



A Case Record

From The University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Burr M. Hathaway, M. D., President

Presented by George J. Hamwi, M. D., and Emmerich von Haam, M. D. Edited by E. von Haam

PRESENTATION OF CASE

THIS 47 year old colored female was apparently well until two years before admission to University Hospital, when she slowly and progressively developed footdrop bilaterally. Within six months she was unable to walk and had since been bedfast. Over the past year she had developed the same sort of weakness in her upper extremities and for two to three months before admission had had severe knife-like pains in her extremities and her skin became very sensitive to touch. She had been taking morphine sulfate for her pains and at the time of admission was on demerol,® receiving 2 cc. every four to six hours.

For three months the patient had had fluid in her abdomen and had been tapped numerous times. The fluid appeared clear and yellowish. Since x-ray examination revealed bone lesions, a specimen for biopsy was taken from her ribs, which revealed no evidence of a neoplastic process. The clinical diagnosis at the onset of her illness was "infectious neuronitis." In the last year she also had pneumonia and at that time had unexplained swelling of both legs. The patient gave a history of drinking about one pint of whisky a month. She had been anorexic during the latter part of her illness and had lost considerable weight.

The patient had undergone a complete hysterectomy six years ago for "tumor." She had received many transfusions in the past for anemia. The family history revealed questionable tuberculosis in the mother's family.

Physical Examination: The patient was emaciated and chronically ill. The temperature was 97°, pulse 100, respirations 24, blood pressure 110/70. The pupils did not react to light. There was a brownish-green ring about the pupils suggesting a Kayser-Fleischer ring as seen in Westphal's pseudosclerosis. The right eyelids were swollen. The fundi showed a primary optic atrophy.

The trachea was deviated to the right. The right chest was flattened. The right breast had a large, hard, movable mass in the upper portion. The heart was not enlarged and no murmurs were heard. Both lung bases were dull on percussion; there were moist rales over the right chest anteriorly and posteriorly from base to apex.

The abdomen was distended with fluid; there was shifting dullness and a distinct fluid wave could be elicited. The liver dullness extended two fingers below the costal margin. No masses could be palpated. The extremities showed 1 to 2 plus pitting edema. There was weakness with limited motion of the knee and hip joints. The elbows could not be straightened over 140 degrees. There was atrophy of all muscles of both hands; the digits were held in hyperextension. The skin appeared tight over the hands and feet.

Neurological examination revealed generalized muscular weakness; the deep tendon reflexes were absent; the vibration sense was present; the skin of both lower extremities was markedly hypersensitive. There was a primary optic atrophy. The patient showed intention tremors.

Laboratory Data: The red blood cell count was 2.27 million, with a hemoglobin content of 6 Gm.; the white blood cell count was 10,000 with a differential count of 80 per cent neutrophils, 19 per cent lymphocytes and 1 per cent monocytes. The red blood cells appeared macrocytic with rouleau formation and marked clumping on the slide. During her stay in the hospital the red blood count dropped to 1.52 million, the hemoglobin to 4.9 Gm.

The urine examination revealed a specific gravity of 1.015 with traces of sugar and 1 granular cast, 3 red blood cells and 1 white blood

cell per high power field. Tests for Bence Jones protein in the urine were negative.

Blood chemistry showed a total protein of 5.8 Gm. with 2.25 Gm. of albumin and 3.55 Gm. of globulin. The van den Bergh reaction was direct and indirect negative. The blood urea nitrogen was 59.5 mg., the blood sugar 43 mg. The blood phosphorus was 4.98 mg., the alkaline phosphatase 4.62 units. The cephalin flocculation test and the thymol turbidity test were weakly positive. The prothrombin time was 30 per cent. All serological tests for syphilis were negative.

The spinal fluid examination showed a sugar content of 21.5 mg. and a first phase colloidal gold curve (paretic curve). Examination of the abdominal fluid showed a specific gravity of 1.012 and a protein content of 1200 mg. Examination of the cells revealed no malignant cells. Tests for occult blood in the feces gave one positive and three negative reactions. Repeated determination of the various tests gave approximately identical figures with the exception of the blood urea nitrogen, which rose slowly to 172 mg. A bone biopsy done at another hospital showed sclerosing bone without evidence of a neoplastic process.

X-Ray Examination: X-ray examination of her lower extremities showed marked lack of soft tissue density, suggestive of severe muscular atrophy. Films of the abdomen and chest showed a distended abdomen, edema of the soft abdominal tissues and a large liver. There was evidence of free fluid in the abdomen. The heart appeared within normal limits. The esophagus appeared distended but no varicose veins could be distinguished.

The ribs showed peculiar densities which did not appear to be associated with any bone destruction. Roentgenogram of the skull appeared normal. Other sclerotic lesions could be found in the left humerus and the iliac bones. These lesions were interpreted as probable metastatic bone lesions. Later the patient developed evidence of pleural effusion and pneumonia.

Hospital Course: During her ten-day stay in the hospital the patient was treated with various analgesics for her severe pains and in addition received forced feedings, insulin and vitamins. However, she gradually became weaker and finally comatose. In spite of all therapeutic efforts her blood urea nitrogen started to rise and she expired on the eleventh hospital day.

CLINICAL DISCUSSION

DR. G. J. HAMWI: We have before us a patient who came to the hospital with exquisite pains for which she had been taking morphine, marked loss of weight, ascites and peripheral edema. She had some fluid and some pneumonic process in her chest, and the neurological examination revealed hyperesthesias of the lower extremities, loss of deep reflexes and optic nerve atrophy with loss of reaction to light. The most important feature was that of severe and possibly terminal cachexia.

Her x-ray examination revealed lesions which were interpreted as metastatic lesions and with the lumps felt in her breasts it is understandable that a diagnosis of carcinoma of the breast with widespread metastasis was suggested.

What facts speak against such diagnosis? First of all, the lesion had apparently been there for at least two years. The breast lumps remained freely movable and apparently did not enlarge. The metastatic lesions to the bone would have to be osteoblastic rather than osteolytic and the latter is the more common occurrence. The normal alkaline phosphatase values also speak against such diagnosis. Biopsies of both breasts and of the bone lesions as early as two years ago failed to reveal carcinoma. So for these reasons I feel that we are not dealing with a case of carcinomatosis arising from a cancer of the breast.

MALNUTRITION?

Most of the symptoms the patient had can be explained by simple severe malnutrition. It could account for the emaciation, the hypoproteinemia, the edema and the ascites. These symptoms were repeatedly observed in starving prisoners in the Second World War. One difficulty is to explain the footdrop and the other neurological symptoms. A group of prisoners released from Stalingrad showed in addition to simple symptoms of starvation signs of beriberi.

As you remember, this disease is very often associated with neurological symptoms. It starts with parasthesias in the extremities, particularly the lower ones, and the progressive weakness results ultimately in footdrop. Then chronic beriberi leads to generalized weakness with paresthesias and bilateral wristdrop. Associated with these symptoms we usually find cardiac enlargement and right ventricular failure. In beriberi the deep reflexes are also lost, the vibratory sense often cannot be demonstrated, and the patients develop anesthesia over the tibiae. None of these symptoms was present.

One important set of symptoms was that of vomiting and diarrhea. The latter was present throughout the course in the hospital and for about six weeks prior to admission. However, dermatitis was absent and for this reason we can rule out pellagra. The hypoglycemia the patient showed also does not fit the picture of starvation. There we usually find a normal blood sugar level maintained until the patient is in extremis.

CHRONIC INTOXICATION

The possibility of some chronic type of intoxication must be considered. Lead poisoning enters one's mind in the case of peripheral neuropathies. It is also associated with anemia although of the normocytic type. This patient had no history

of exposure to lead. Her blood cells were not stippled. Arsenic usually runs a more acute course and chronic arsenic poisoning is associated with skin manifestations. Alcoholic neuritis also may simulate dry beriberi, but the alcohol consumption of the patient cannot be considered excessive. The intake of morphine over a long period of time probably played some role in her anorexia and thus her malnutrition.

Finally, we are faced with the problem as to whether we are dealing with a case of primary pituitary disease such as Simmonds' disease, or primary pituitary cachexia. Such condition may be due to destruction of the pituitary gland as we see in postpartum necrosis or due to a tumor, metastatic or primary in nature, which destroys the functioning portion of the gland, or due to a granuloma. This primary hypopituitarism has to be differentiated from secondary pituitary deficiency as seen in anorexia nervosa. Here too we find general atrophy, loss of libido, loss of hair, weakness and hypoglycemia with bizarre neurological manifestations, but this can be cured by simply feeding the patient. The patient did not show the metabolic changes typical for primary hypopituitarism and also did not show the generalized microsplanchnia commonly present with this condition. By the latter we mean an atrophy or arrest in development of all body structures including the parenchymatous organs.

In summary then, I believe that most of the symptoms of the patient are due to either simple starvation or pituitary insufficiency. I cannot explain the footdrop on the basis of any primary disease. I feel that the lesions in the breast are probably benign and that the bone lesions also are unassociated with the illness of the patient. I think that in addition to starvation and/or pituitary deficiency the patient showed definite signs of vitamin deficiency of the type of wet beriberi. I do not think that she suffered from a primary renal disease, and I do not think that she suffered from tuberculous peritonitis. Her central nervous system lesions I am going to ascribe to degenerative changes secondary to the emaciation and malnutrition.

CLINICAL DIAGNOSIS

1. Severe malnutrition.
2. Avitaminosis of the beriberi type.
3. Secondary hypopituitarism.

CLINICAL DISCUSSION

DR. HARD: How do you explain her uremia?

DR. HAMWI: I consider it prerenal in origin. It represented a terminal course of events and can be explained by the marked anemia, the chronic diarrhea and the vomiting.

MEDICAL STUDENT: How much weight did she lose?

DR. VON HAAM: Her original weight was mentioned as 140 and her estimated weight at autopsy as 90 pounds. This would mean a loss of 55 pounds, or over 30 per cent.

MEDICAL STUDENT: Was the spleen enlarged?

DR. MORTON: The splenic shadow was obliterated by the fluid present in the abdomen.

DR. HAMWI: How about the bone lesions, Dr. Morton?

DR. MORTON: Well, first we thought that they were sclerotic metastases, but on looking at them again we now doubt it. They were not associated with any evidence of bone destruction and were too sharply outlined to be metastatic neoplasms.

PATHOLOGIC DIAGNOSIS

1. Avitaminosis with:
   (a) polyneuritis;
   (b) ascites;
   (c) peripheral edema.
2. Severe malnutrition with cachexia.
3. Toxic myocarditis.
4. Mild chronic pyelonephritis.
5. Uremia.

PATHOLOGIC DISCUSSION

The patient was a well developed, markedly emaciated female with an estimated weight of 90 pounds. There was marked atrophy of the muscles of all extremities. The right breast showed a vague nodularity. Both ankles and shins showed 2 plus pitting edema. The abdomen was distended and showed a distinct fluid wave. The peritoneal cavity contained about 600 cc. of clear straw-colored fluid. The right thoracic cavity contained 200 cc. of a similar fluid. The heart muscle was brown and soft. The pericardial fat showed a severe degree of serous atrophy. The lungs were free of pathologic change.

The liver weighed only 850 grams and showed a brownish-red mottling of the liver substance. The mucosa of the gastrointestinal tract appeared normal. Both kidneys showed superficial cortical scars. The one ovary found in the pelvis was fibrosed. The brain weighed 1090 grams and showed no gross pathologic changes. The pituitary was of normal size and shape. Examination of the spinal cord and of many peripheral nerves showed no evidence of gross pathology. Cross sections through the bones revealed reddish-pink bone marrow.

MICROSCOPIC EXAMINATION

Microscopic study of the organs revealed a severe hydropic degeneration of the heart muscle fibers together with an increased accumulation of lipochrome pigment. Sections of the spleen showed a severe lymphoid atrophy of the Malpighian corpuscles. Sections of the liver showed a marked atrophy of the liver cells with marked irregularities in the liver cell nuclei. Many liver cells contained two nuclei while in other cells the nuclei appeared large and pyknotic. Sections through the adrenal glands showed cortical lipid depletion. There were many islands of ectopic adrenal tissue in the periadrenal fat. The pitui-

tary appeared normal histologically with slight predominance of basophil cells as frequently observed in menopausal patients. We definitely could rule out primary hypopituitarism.

Section through the pancreas revealed marked hyperplasia of the islands of Langerhans. Sections of the breast showed periductal fibrosis as observed in atrophic breasts of elderly women. Sections of the central nervous system showed only mild patchy atrophy with gliosis without any evidence of systemic or well-defined lesions. The myelin sheath stain applied to the spinal cord and the peripheral nerves showed no striking abnormalities. The bone marrow was quite cellular with many megaloblasts.

In summary then, we feel that the patient died from malnutrition with severe vitamin deficiency as suggested by the clinical discussant. The changes in the heart muscle, liver and pancreas were quite characteristic for those associated with deficiency of the vitamin B complex, while the changes in the remaining organs can well be explained by cachexia with hunger atrophy. Unfortunately we did not examine histologically the posterior root ganglia and thus cannot rule out with certainty infective meningomyeloneuritis (Guillain-Barré syndrome).

GENERAL DISCUSSION

DR. OSER: The patient then did not have a liver cirrhosis as was assumed by us while she was in the hospital?

DR. VON HAAM: The liver changes were purely those of atrophy without fibrosis or evidence of portal hypertension.

DR. HAMWI: Were the patient's adrenal glands enlarged as the result of stress?

DR. VON HAAM: The adrenal glands together weighed 30 grams, which would appear more than normal. However, histologically no glandular hyperfunction was evident.

MEDICAL STUDENT: How do you interpret the findings in the bone marrow?

DR. HAMWI: The bone marrow of starving patients is characteristically hyperplastic with megaloblastic arrest of erythropoiesis.

DR. VON HAAM: In vitamin B complex deficiency megaloblastic anemias have been described and for this reason the bone marrow findings fit well into the diagnosis. I wonder if the basis for the patient's illness was not true anorexia nervosa? Another explanation could also be that of primary neuritis which with its severe pains led to drug addiction followed by starvation cachexia.

DR. HAMWI: Unfortunately the history we elicited was not accurate enough to decide this very important point.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Man—An old Anglo-Saxon word, denoting a human being, which is thought to stem back to the Sanscrit word "manu" meaning a thinker. In India an ancient legend exists concerning a mythical character or sage named "Manu" who supposedly was the progenitor of the human race.

Digest—The literal meaning of this word is to carry apart. This word is composed of the Latin "di or dis" meaning apart, plus "gerere" meaning to carry. The word originally was used in two senses—one being to scatter, and the other to sort. The latter sense of the word prevailed and in the 15th Century, the word came to mean to sort out ideas in the mind. Later the term came to mean the sorting out of the valuable parts of food in the stomach, thus preparing it for assimilation.

Hallux—A Latin word denoting the big toe which is thought to be derived from the Greek word "halmos," meaning to leap or spring. The big toe was supposedly so named because of the part it plays in the act of leaping or springing.

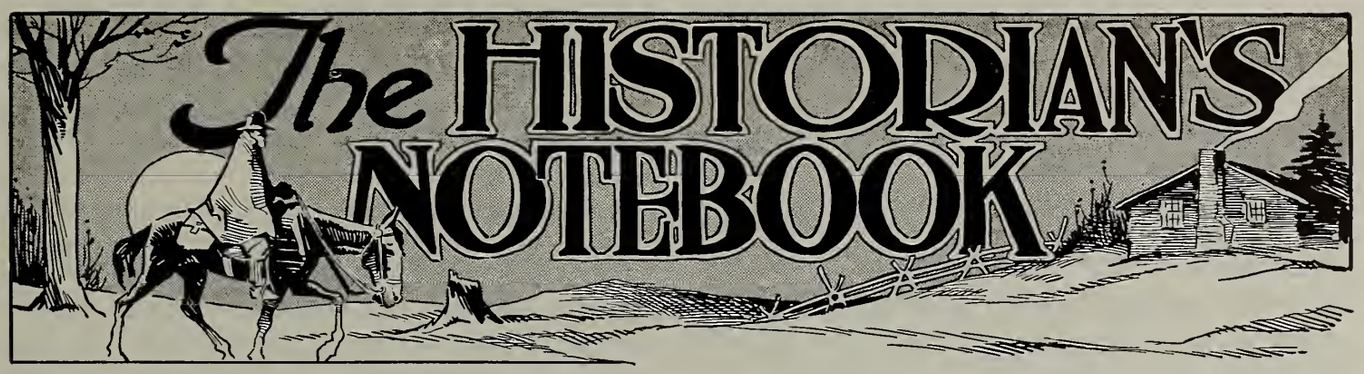
Enema—Literally meaning a medicine "thrown in" to the bowel this word is derived from the Greek word "eniemi" meaning, I cast or throw in. The use of "enemas or clysters" is one of the most ancient of all medical procedures and goes back into antiquity. There is an old Egyptian legend which according to Pliny ascribes the invention of the enema to the sacred bird known as the ibis. This bird supposedly injected water into its bowel by means of its beak.

Ammonia—The Latin word "sal ammoniac" literally means the salt of ammon. This substance was so called because it supposedly was first prepared from the urine of camels collected in a cesspool near the temple of Jupiter Ammon. According to Pliny the name "Ammon" means sand and comes from the sandy district of Libya where the temple of this god was situated. Later the gas obtained from this salt was called ammonia.

Embalm—In order to preserve dead bodies from decay the ancients filled the internal parts with various aromatics, balsams, and drugs. Hence the term "embalm" literally means to place "balsam in" and is composed of the Latin "em" or in, plus "balsamum" or balsam.

Bust—A woman's "bust" was originally the entire torso and this word came into English from the French word "buste" meaning the body of a man from the face to the middle. This word came in turn from the Mid-Latin word "busta" meaning the trunk of a tree.

—HARRY WAIN, M. D., Mansfield, Ohio.



Physicians' Role in the Development Of Withamsville, Ohio*

By THE REVEREND FRANCIS J. HEIDER,
St. Thomas More Church, Withamsville (R. R. 1, Amelia, Ohio).

WITHAMSVILLE has been especially blessed by the members of the medical profession. About 1818 William Doane located here as a practitioner. He was elected to congress from this district.

One of his pupils was Dr. Elisha Bennett who became one of the outstanding men of the community. He was of English descent on his paternal and maternal side.

James Bennett, his father, was born in Maine on December 8, 1766. He was married in that state to Catherine Witham. She was born September 2, 1774, and emigrated to Ohio about 1800 settling in what is now Withamsville. This pioneer family had eleven children—six boys and five girls.

Catherine (Witham) Bennett was the daughter of Elder Maurice Witham, a pioneer minister of the Baptist Church. He emigrated from England from that part where the Witham river flows. This river received its name from the early race of Withams in the 10th Century.

Elder Maurice Witham came to Clermont County in 1800 and purchased the entire survey of Churchill Jones—1,000 acres where now stands the fair village of Withamsville. James Bennett died September 16, 1841, and his wife Catherine on February 24, 1847.

Dr. Elisha Bennett, the fourth son of his parents, was born on the farm which forms a part of the community of Withamsville in the year 1809, and always lived, with the exception of one year, on part of the farm where he was born.

HIS EDUCATION

After receiving a common school education he began the study of medicine with Dr. William Doane, his brother-in-law, an eminent physician, who afterwards was representative and senator in the Ohio legislature, and from 1839 to 1843 a member of Congress.

After completing his medical studies Dr. Bennett located for a short time in the far west, where the Indians were numerous and where he practiced his profession for one year.

When the health of Dr. Doane failed to such a degree that he was unable to attend the numerous calls of an extensive practice in Clermont and Hamilton counties, he called Dr. Bennett to his assistance, and he returned to this county to practice his profession.

The doctor was united in marriage August 27, 1836, by John McGuire, Justice of Peace, to Miss Hannah Smith, of this county, and to this union were born ten children. Of these, William D. Bennett, was in the insurance business and general speculation; Dr. Cass A. Bennett, a rising physician of promise and ability; and Harvey H. Bennett, the youngest, engaged in mercantile business.

In 1833, Dr. Elisha Bennett was appointed as adjutant on the staff of Col. William Thomas, and after serving some time on his staff was promoted, in 1839, to lieutenant colonel, and finally to colonel of the regiment. This office he held until the legislature of Ohio repealed the milita law, and the doctor, with others, was legislated out of office.

In 1851 Dr. Bennett was elected a representative from Clermont County to the 50th General Assembly of Ohio by the Democratic party, and the first under the new constitution adopted that year.

He was a strong advocate of the rights of the people, and opposed to high salaries on the part of public officials. Through integrity and

*Reprinted from the December 3, 1953, issue of *The Clermont Courier*, Batavia, Ohio.

honesty he stood foremost among his fellow-citizens, always contributing to public charities and enterprises with a liberal hand.

Though for some years greatly afflicted with a nervous disease affecting his voice, Dr. Bennett bore his sufferings with remarkable patience so characteristic of his strong mind and kind disposition.

On one occasion, while traveling on a visit to one of his patients, his horse was brought to his knees by a stroke of lightening, yet the doctor escaped serious injury, being only temporarily blinded by the vividness of the flash.

On another occasion his dwelling was struck by lightening and considerably damaged, yet he and his family were not hurt.

May we not attribute the deliverance of the doc or from these and frequent kindred perils to the fulfillment of that which is written in Holy Writ: "Honor thy father and thy mother, that thy days may be long in the land," for surely no person ever treated with more loving kindness and respect his parents than did Dr. Bennett.

HIS CHARACTER

He was proverbially kind and profoundly respectful to all old people with whom he came in contact. His honest life, his public service, his humane character, and his medical career in behalf of humanity will make him a monument more enduring than brass or marble.

He practiced his profession at Withamsville from 1830 to 1878, when he retired.

Dr. Doane died here June 20, 1847. From 1847 Dr. J. C. Webber was a practicing physician in the village and later Drs. H. L. Donham and J. C. Collins. Since 1851 Dr. J. M. Witham followed the profession and since 1873 was associated with his son, F. P. Witham.

Dr. F. P. Witham's wife is still living and was 97 years old September 12, 1953. She lives with her niece, Mrs. Mabel Higdon at 3515 Shaw Avenue, Hyde Park, Cincinnati, Ohio.

In 1879, Dr. C. A. Bennett, son of the veteran Dr. Elisha Bennett, commenced his career as a physician. Many will remember him.

As I write the history of these physicians, who are deceased, I think of the worthy successor we have to these eminent men in Dr. Frederick Paul Baurichter.

Like Dr. Elisha Bennett, Dr. Baurichter has a large family. I called him on the phone to be sure of the number of children and he told me he had ten. His honest and frank diagnosis has won for him a great number of patients.

What a group of happy children can do to gladden the righteous heart of every citizen. It dispels much of the selfishness of those who want to run their own lives in defiance of God and country.

Richard Allison, Pioneer Physician Of Early Cincinnati Area

With the arrival of Dr. Richard Allison at Fort Washington in 1789 the medical history of Cincinnati begins.

Allison was born near Goshen, Orange County, New York in 1757. At twenty-one years he joined the Fifth Pennsylvania Regiment of Continental Infantry as a surgeon's mate . . . The end of hostilities found him still in the same grade, . . . nevertheless, he remained in the army . . . Promotion finally came with his appointment as surgeon . . . Allison participated in General Harmar's action against the tribes on the



Silhouette of
DR. RICHARD ALLISON
(Courtesy of Armed Forces Medical Library)

Maumee-Wabash portage (1790). The following year at St. Clair's defeat he "displayed a great share of military zeal in action by encouraging the broken ranks and assisting officers to rally them to the charge."

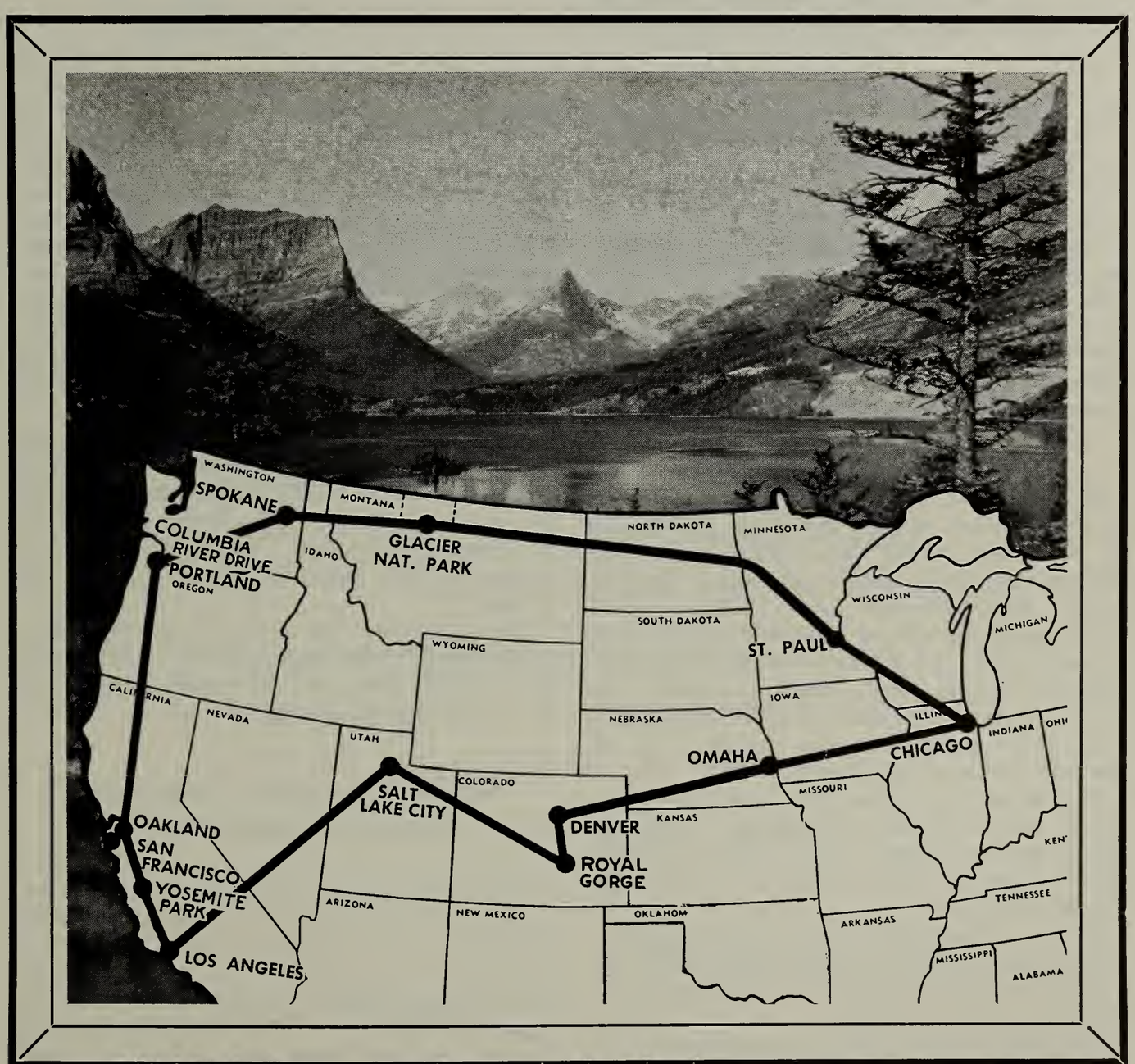
A reorganization of the military ensued. Anthony Wayne became commander of the newly formed Legion of the United States, and Allison was assigned to his staff as surgeon to the Legion. He was with Wayne at the victory of Fallen Timbers. . . . He retired from the army, his discharge being dated November 1, 1796.

Early in 1800 he occupied a plantation that he had bought where Stone Lick Creek joins the East Fork of the Little Miami. Here he cultivated the land and brought medical care to his neighbors, being the only physician, until 1804, in the whole of present-day Clermont and Brown counties. Back in Cincinnati in 1809 he joined Dr. Samuel Ramsey in "the practice of physic and the vending of medicine." After a short illness Dr. Allison died on March 22, 1816. His remains lie in Wesleyan Cemetery, Colerain Avenue, Cincinnati. The Academy of Medicine is planning a plaque to mark his "Peach Grove" residence.—Virginus C. Hall in *The Cincinnati Journal of Medicine.*

Here's the Picture . . .

You'll See From the Windows of the O.S.M.A. Special Train

Not one picture—but dozens of them—for you—for your family—Nature's own great out-of-doors in all of its glory—the Royal Gorge—Salt Lake City—Yosemite National Park—the Pacific Ocean—the Columbia River Drive—Glacier National Park—Other Scenic Wonders of the Great Wide West.



Join your fellow physicians and their families on the Ohio State Medical Association Special Train—leaves Chicago June 12. Attend the American Medical Association Meeting in San Francisco.

FOR INFORMATION — PRICES — ETC., WRITE THE COLUMBUS OFFICE. BETTER HURRY — SPACE IS GOING FAST.

Rural Health . . .

Ohioans Take Leading Roles in National Conference; Profession and Farm Leaders Working Together; Individual Responsibility Stressed

THE fact that the medical profession and farm leaders now possess a "unity of purpose and performance in stimulating rural people to attain a fuller and more healthful life" was demonstrated at the Ninth National Conference on Rural Health, held in Dallas, March 4-6, according to a statement issued by the American Medical Association following the meeting.

"Several speakers stressed the fact that medicine is no longer a job for the doctor alone—it's a problem for the community. In fact, the health of the community is a part of the duty of the community itself," the report stated.

Opening the meeting, Dr. George F. Lull, secretary and general manager of the American Medical Association, said: "Public health facilities must be extended to cover all areas so that there will be universal protection against communicable diseases, protection of food, milk and water supplies, elimination of disease-bearing insects, and adequate environmental sanitation."

McCORMICK AND MUNDY SPEAK

Dr. Edward J. McCormick, Toledo, president of the American Medical Association, addressed the conference, calling for a "restoration of the independent spirit which has made America great." He discussed a number of the activities of the American Medical Association in the field of rural health, and expressed the hope that "cooperation between the medical profession and the rural groups will continue until every rural area of our great country is supplied with the best that medicine can give."

The theme of the meeting, "Let's Put More 'U' in Community" was sounded by Dr. Carll S. Mundy, also of Toledo, who is acting chairman of the Council on Rural Health of the American Medical Association.

He said, "The measure of success of any community health effort is in direct proportion to the extent to which all elements of the community participate in the effort.

"We believe that maintenance of health is, to a large extent, the responsibility of the individual and to a lesser extent the responsibility of his community. It is an individual's responsibility, acting collectively with others, to see to it that the proper health measures are in force.

"Therefore, it follows that the health of the community is, in the last analysis, the responsibility of each individual in that community."

Major topics for discussion included the promotion of community programs; nutrition problems of farm families, and the what, how and why of health insurance. One of the members of the panel presenting the last named topic was Mr. James Stuart, executive director of Hospital Care Corporation, Cincinnati.

OTHER OHIOANS PARTICIPATE

An extended discussion period followed the presentation of each problem, under the leadership of Mr. J. P. Schmidt, professor of rural sociology, Ohio State University, Columbus. Mr. Schmidt was assisted in conducting the discussion program by a Columbus team which included Mr. R. Bruce Tom, lecturer of the Ohio State Grange; Mr. Sewall O. Milliken, chief, Division of Health Education, Ohio Department of Health, and Mr. Hart F. Page, assistant director of public relations, Ohio State Medical Association and secretary of the Association's Committee on Rural Health. Mrs. Schmidt aided in arranging details of the discussion sessions.

Enthusiastic observers at the meeting, and taking part in discussions, were three members of the Ohio State Medical Association's Committee on Rural Health. They were: Dr. Edmond K. Yantes, Wilmington, chairman; Dr. E. G. Caskey, Mineral Ridge, and Dr. V. R. Frederick, Urbana.

Other Ohioans who participated were Mrs. Carll Mundy, a member of the Ohio Legislature; Mrs. Harold Robinson, Ashtabula, representing the Farm Bureau, and Mrs. Caskey.

Health Information Foundation Names Bugbee President

George Bugbee, for the past 11 years executive director of the American Hospital Association, Chicago, has been appointed president of Health Information Foundation. He succeeds the late Admiral W. H. P. Blandy and will assume his new post about May 1. From 1938 to 1942, Mr. Bugbee was director of Cleveland City Hospital.

Organized four years ago, H. I. F. has been supported as a public service by 165 drug, pharmaceutical, chemical and allied companies. Currently it is engaged in five fact-finding and public relations projects dealing with the costs of medical care and health insurance. It announced January 24 results of a national survey providing for the first time in 20 years comprehensive consumer statistics regarding family medical expenses and health insurance.



Remember
These Dates

April 12, 13, 14, and 15

Ohio State Medical Association

ANNUAL MEETING

Neil House ★ **Deshler-Hilton Hotel**

Columbus

12 Specialty Section Programs - - - - General Sessions - - - - - 10 Out-of-State Guest Speakers - - - - Specialty Society Meetings - - - - Scientific and Educational Exhibits

Sessions of the House of Delegates - - - -

Technical Exhibits - - - Entertainment for the Ladies by the Woman's Auxiliary - - - -

Conference of County Society Officers and P. R. Chairmen - - - - - The Annual Banquet - - - - - Class Reunions and Other Get-Togethers.

Five Credit Hours Have Been Authorized by the Ohio Academy of General Practice For Its Members Who Attend Sessions of the O. S. M. A. Annual Meeting

Turn the page for Summary of Program

Refer to March Issue for Complete Details

Summary of the 1954 Annual Meeting Program

Ohio State Medical Association, Columbus, April 12 - 15

MONDAY, APRIL 12

9:00 A. M.- 9:30 P. M.—Ohio State Surgical Association
11:00 A. M.- 9:00 P. M.—Ohio Psychiatric Association
3:00- 9:00 P. M. —Ohio Academy of General Practice
4:00- 6:30 P. M. —Ohio Chapter, American Academy of Pediatrics
4:00- 9:00 P. M. —Ohio Section, American Academy of Obstetrics and Gynecology
6:00 P. M. —House of Delegates, O. S. M. A.

TUESDAY, APRIL 13

8:00 A. M. —Registration Opens
9:30 A. M.-12:10 P. M.—Section on General Practice
9:30 A. M.-12:00 Noon —Section on Obstetrics and Gynecology and Section on Pediatrics (Combined Session)
9:30 A. M.-12:10 P. M.—Section on Ophthalmology
9:30 A. M.-12:20 P. M.—Section on Surgery
9:30 A. M.-12:00 Noon —Section on Urology
10:00 A. M.- 4:00 P. M.—Ohio Psychiatric Association
2:00- 3:30 P. M. —General Session
3:45- 9:00 P. M. —Conference of Officers and Public Relations Chairmen of County Medical Societies (An invitational event.)
6:00 P. M. —Joint Meeting of Central Ohio Radiological Society and Section on Radiology

WEDNESDAY, APRIL 14

8:00 A. M. —Registration
9:30 A. M.-12:00 Noon —Section on Anesthesiology
9:30 A. M.-12:00 Noon —Section on Internal Medicine
9:30 A. M.-12:00 Noon —Section on Neurological Surgery
9:30 A. M.-12:10 P. M.—Section on Otorhinolaryngology
9:30 A. M.-12:00 Noon —Section on Physical Medicine
9:30 A. M.-12:00 Noon —Section on Radiology
12:15 P. M. —Ohio Chapter, American College of Chest Physicians
12:30 P. M. —Women's Medical Society of Columbus
2:00- 4:00 P. M. —General Session
7:30 P. M. —Annual Banquet

THURSDAY, APRIL 15

8:00 A. M. —Registration
8:00 A. M. —House of Delegates
9:30 A. M.-12:00 Noon —General Session
1:45- 4:15 P. M. —Ohio State Heart Association

For Complete Details Refer to March Issue of The Journal



Oops! Forget Something?

That HOTEL RESERVATION for the 1954 ANNUAL MEETING, APRIL 12-15? It's a bit late, but worth trying. Mail the coupon at the bottom of the page special delivery to the hotel of your choice.

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BEDS
NEIL HOUSE	$5.50-7.00	$8.00-10.00	$10.00-13.00
DESHLER-HILTON HOTEL	$5.00-9.00	$9.00-13.50	$ 9.50-14.50
HOTEL FORT HAYES	$5.50-8.00	$8.50-10.00	$10.00-11.00
SENECA HOTEL	$4.00-6.00	$6.00- 8.00	$ 8.00-10.00
SOUTHERN HOTEL	$5.00-6.00	$6.50- 8.50	$10.00-11.00
HOTEL VIRGINIA	$4.50-5.00	$7.50- 8.00	$ 8.00- 9.00
HOTEL CHITTENDEN	$3.50-4.00	$5.00- 6.75	$ 6.75-10.50

Persons who desire suites or other additional accommodations are advised to specify their needs to the hotel of choice.

(All rates subject to change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager.....Hotel, Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 12, 13, 14, 15, 1954, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Additional Accommodations (Specify)

Arriving April.....at.....A.M.....P.M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

Ohio Psychiatric Association Program For Annual Meeting

The Ohio Psychiatric Association has announced the following details of its program on Monday and Tuesday, April 12 and 13. Please refer to the March issue for other features of the 1954 Annual Meeting of the Ohio State Medical Association.

MONDAY, APRIL 12

Sapphire Room
Fort Hayes Hotel

10:00 to 10:20 A. M.

SYNDROME OF THE "CONTROLLING" PATIENT IN A PSYCHIATRIC HOSPITAL

Robert B. Stevenson, M. D., Columbus.

10:30 to 10:50 A. M.

TWO NEAR-FATAL IATROGENIC NEUROSES

John S. Horan, M. D., Cleveland.

11:00 to 11:20 A. M.

THE EFFECTS OF CONSCIOUS AND UNCONSCIOUS AWARENESS ON AN ARTIFICIALLY INDUCED ANXIETY

B. William Tanner, Ph. D., Toledo (By Invitation).

11:30 to 11:50 A. M.

PREVENTIVE PSYCHIATRY—A PRACTICAL APPROACH IN PUBLIC SCHOOLS

J. Hertzman, M. D., Cincinnati.

12:30 to 2:00 P. M.

JOINT COUNCIL COMMITTEE LUNCHEON

2:00 to 2:20 P. M.

THE TREATMENT OF BARBITURATE POISONING

Nicholas Michael, M. D., and Calvin Baker, M. D., Columbus.

2:30 to 2:50 P. M.

DEPRESSIVE REACTIONS IN TEMPORAL LOBE-UNCINATE SEIZURES

Andre A. Weil, M. D., Cleveland.

3:00 to 3:20 P. M.

TREATMENT OF PERSONALITY DISORDERS (PSYCHOPATHS) IN A SHORT TERM PSYCHIATRIC HOSPITAL

Dorothea M. Smith, Ph. D., Columbus (By Invitation).

3:30 to 3:50 P. M.

VENTRO-MEDIAL QUADRANT COAGULATION IN THE TREATMENT OF THE PSYCHOSES AND NEUROSES

Howard D. McIntyre, M. D., Frank Mayfield, M. D., and Aurelia P. McIntyre, M. D., Cincinnati.

4:00 to 5:00 P. M.

MILIEU THERAPY IN THE DAY HOSPITAL

Lewis L. Robbins, M. D., Menninger School of Psychiatry, Topeka, Kansas (By Invitation).

5:00 to 6:00 P. M.

GENERAL BUSINESS MEETING

7:00 to 9:00 P. M.

SOCIAL SESSION—COCKTAILS AND BANQUET

TUESDAY, APRIL 13

10:00 to 10:20 A. M.

AN EXPERIMENT IN UTILIZING PSYCHOLOGISTS AND PSYCHIATRIC SOCIAL WORKERS IN SUPERVISED PSYCHOTHERAPY IN PRIVATE PRACTICE

Arnold Allen, M. D., and Harry L. MacKinnon, M. D., Dayton.

(Continued in next column)

Special Telephone and Paging Service During Annual Meeting

Arrangements have been made through the courtesy of the Columbus Academy of Medicine for special paging service for physicians attending the Ohio State Medical Association Annual Meeting, April 12-15, Columbus.

A special telephone line with this special number—MAin 1543—will be installed at the Neil House. Information and paging desks will be maintained at the Neil House and the Deshler-Hilton Hotel.

Physicians expecting calls should have such calls placed through MAin 1543. This number will be used, also, to reach physicians in cases of emergency.

Since the meeting is divided between the two hotels, the paging service may not work perfectly, but every effort will be made to reach physicians for important and emergency calls as promptly as possible.

10:30 to 10:50 A. M.

ANXIETY AND DEPRESSIVE STATES TREATED WITH ISONICOTINYL HYDRAZIDE (ISONIAZID)

Harry M. Salzer, M. D., and Max L. Lurie, M. D., Cincinnati.

11:00 to 11:20 A. M.

A SURVEY OF THE GRAPHIC PRODUCTIONS OF PSYCHIATRIC PATIENTS

Marguerite McDonald, O. T. R., Elaine R. Jacobson, O. T. R., and Kathryn Young, O. T. R., Columbus (By Invitation).

11:30 to 11:50 A. M.

DEGENERATIVE CHANGES IN NERVE CELLS AND IN HYPOPHYSIAL CELLS IN MENTAL ILLNESS. NATURE OF ASSOCIATED INFESTATION

James W. Papez, M. D., Columbus.

12:00 Noon to 2:00 P. M.

LUNCHEON

Special Speaker: Daniel Blain, M.D., Washington, D.C., Medical Director, American Psychiatric Association; Topic—"Matters Concerning American Psychiatric Association."

2:00 to 2:20 P. M.

THE INFLUENCE OF PENSIONS ON PSYCHIATRIC TREATMENT

Robert W. Buckley, M. D., and Warren L. Richards, M. D., Cincinnati.

2:30 to 2:50 P. M.

HYPNO-COALESCENCE

Richard N. Nelson, M. D., Chagrin Falls.

3:00 to 3:20 P. M.

HUSBANDS OF POSTPARTUM PSYCHOTICS

Susan Beach, Katherine Henley, Anita Peterson and Mildred Farr, Columbus (By Invitation).

3:30 to 3:50 P. M.

TODD'S PARALYSIS

John A. Whieldon, M. D., Columbus.

Polio Field Trials . . .

Three Counties Are Named in Ohio for Test of Vaccine; Program To Get Under Way Early in April; Gamma Globulin Program To Continue

POLIOMYELITIS vaccine field trials will be conducted in Ohio in three counties—Montgomery, Richland and Summit—according to an announcement from Dr. John D. Porterfield, director of the Ohio Department of Health. The trials will begin early in April.

In the meantime, the program for distribution of gamma globulin through the Office of Defense Mobilization will continue this year with some modification.

Counties selected for the vaccine program are among those which have had a relatively high poliomyelitis incidence in the past. Each county selected also has adequate medical and health facilities. The trials were planned and will be conducted with the approval and cooperation of the medical society, boards of education, board of health and other groups in each county. The Ohio State Medical Association through The Council has approved the program.

Injections will be given to children in the first, second and third grades in the counties indicated, but only to those children whose parents have returned a signed request form. Dr. Porterfield estimated that there are approximately 61,000 children in the three grades in the three counties.

The nation-wide field trials are being sponsored by the National Foundation for Infantile Paralysis, health departments and many organizations interested in medicine and health. The purpose is to evaluate the polio vaccine developed under direction of Dr. Jonas E. Salk, of the University of Pittsburgh. This vaccine is an aqueous suspension of formalin-killed poliomyelitis virus of all three known immunologic types. The virus is grown on monkey kidney tissue culture in a synthetic medium (Mixture 199 composed of amino acids and Earles' salt solution).

Methods of conducting the nation-wide tests will differ among the states. In Ohio, half of the children whose parents consent to the trials will be given the vaccine. The other half will be given a salt solution and will be used as controls. In certain other states only second grade children will be given the vaccine, while first and second grade pupils will be used as controls.

SAFETY

Approximately 5,000 children and adults have been inoculated under controlled conditions with one or more injections of this material. There has been no evidence of the appearance of poliomyelitis or of other untoward effects. Laboratory examinations have revealed no evidence of liver or kidney damage or of sensitization to monkey kidney. Tissue culture and monkey inoculation with samples from each lot of prepared vaccine are routine procedures conducted to assure the absence of viable virus. Dr. Salk stated that he has observed no local reaction to the vaccine.

METHOD OF ADMINISTRATION

The vaccine is given by intramuscular injection into the deltoid muscle mass. A total of three injections of 1 cc each are given, the second injection one week after the first and the third injection one month following the second.

EVIDENCE OF EFFECTIVENESS

Antibody production as measured by virus neutralization tests has been demonstrated in over 95 per cent of Dr. Salk's preliminary test individuals. In some instances the antibody response has been greater than that following naturally occurring poliomyelitis. These facts are very suggestive but not conclusive evidence of the production of artificially induced immunity by the vaccine. The field trials are designed to prove or disprove the effectiveness of vaccine protection in humans under natural conditions.

PLAN OF STUDY

All of the study children will be given a course of three injections. Half of the group will be given the Salk vaccine and the other half will be given identical amounts of innocuous salt solution placebo. The material will be packaged and identified by a code, the key to which will be known only to the manufacturer of the material. The children who are actually given the vaccine material will, therefore, not be known until the results of the study have been properly evaluated.

In about 10 per cent of the children a 10 cc sample of blood will be drawn at the time of the first injection and two weeks following the third injection.

During the summer following the immunization, careful follow-up of each reported case of poliomyelitis in the study group will be undertaken. The results of the trials will be analyzed at the Evaluation Center, University of Michigan, under the direction of Dr. Thomas Francis.

ADMINISTRATION OF THE STUDY

The study will require the very close cooperation of the medical society, the school authorities

and the local department of health. The local director of the study for each of the selected areas will be the health commissioner for that health jurisdiction. He will be responsible for the definitive administrative protocol to be utilized in his area.

The actual inoculations will take place in the schools and will be given by teams of volunteering local physicians. Nursing assistance will be given by the local public health and school nurses. Volunteer assistance as needed will be provided by the local chapter of the National Foundation for Infantile Paralysis. The vaccine-placebo inoculation, blood drawing equipment and records will be provided by the National Foundation and will be distributed by the local health commissioners according to an acceptable protocol. Blood samples will be shipped to one of 16 participating laboratories where antibody levels will be determined.

As the summer progresses all reported cases of poliomyelitis will be carefully evaluated and specimens of blood and stool will be obtained for study. A thorough statistical analysis of the incidence of poliomyelitis in the study group will be made at the Evaluation Center and the results will be pooled with those from studies being conducted in other states.

PARTICIPATION BY LOCAL PHYSICIANS

Enthusiastic participation in the study by local physicians is essential to insure success in the operation of this program, Dr. Porterfield emphasized. In addition to volunteer assistance in the inoculation it will be necessary that physicians grant permission for prompt examination by an epidemiologist of all cases occurring during the year in this age group. An examination of the patient by a physiotherapist 10 to 20 days and again 50 to 70 days after the onset of the disease will also be necessary for the proper evaluation of the extent of paralysis, Porterfield said.

GAMMA GLOBULIN PROGRAM

Dr. Porterfield, a member of the national advisory committee to evaluate gamma globulin, said that distribution of gamma globulin will continue to be administered by the office of Defense Mobilization through state health departments, since the supply has not as yet approached the potential demand. Distribution in Ohio is through the Ohio Department of Health, through local health departments.

Dr. Porterfield said that a letter from the Office of Defense Mobilization indicated that g. g. for the alleviation of measles and infectious hepatitis would be in ample supply. He added that he would do everything possible to cooperate with Ohio physicians as to their requirements for these purposes.

The committee, after evaluating nationwide data on last summer's inoculations, reported that: (1) Observation of communities where mass inoculations were given does not provide sufficient evidence to determine the efficacy of the serum in preventing the disease or alleviating its effects by this method. (2) Mass inoculations in most instances were given after the epidemic peak, which made evaluation of the effects of g.g. on the epidemic difficult and uncertain. (3) Family-contact administration of the serum (where all household members were inoculated immediately upon recognition of a polio case) did not appreciably lessen subsequent family incidence of paralytic polio. (4) Inoculation of exposed persons caused no measurable difference in the severity of ensuing paralysis. (5) More experience and greater opportunity for scientific investigation is necessary for proper evaluation of gamma globulin in mass inoculations.

Complete details of the future plans were still under consideration as this issue went to press.

None of the 23 communities in which mass inoculations were carried out last year were in Ohio.

Commenting on the committee's finding, Dr. Porterfield said that it is evident that by the time polio is demonstrated in a patient it is too late for g. g. inoculation to be effective on family contacts. In larger groups—schools, playgrounds, clubs, etc.—the contacts presumably are less exposed than in the family circle. Success in inoculation of such groups, he said, seems to hinge upon getting to the group early enough with an ample supply of g. g.

Dr. Porterfield further indicated that additional information is desirable as to the methods of administering g. g. to group contacts. Time and dosage are two elements that must be determined by experience, he said.

Jefferson Medical College Alumni

The fourth annual dinner in Ohio of the Jefferson Medical College Alumni Association will be held in the University Club of Columbus, 40 S. Third St., on Tuesday, April 13, beginning with a cocktail hour at 6:00 p. m. This is the second day of the Annual Meeting, Ohio State Medical Association. Alumni, their wives and guests are invited at a nominal charge per plate. Dr. Anthony Ruppersberg, Jr., 336 E. State St., Columbus, is in charge of arrangements.

American Geriatrics Society

The 11th Annual Meeting of the American Geriatrics Society will be held at the Fairmont Hotel in San Francisco just preceding the meeting of the American Medical Association. The scientific sessions of the meeting will begin Thursday afternoon, June 17, and continue through Saturday morning, June 19. Hotel reservations should be made through the San Francisco Convention and Visitors Bureau, 200 Civic Auditorium, San Francisco 2, California.

According to the Record . . .

A.M.A. Not Just "Agin" As Newspaper Editorial Charges But Has Supported Proposals Which Would Benefit Public, Facts Reveal

ON February 6, the *Kansas City Star* published an editorial, which, for the most part, assailed the American Medical Association for what it termed the A. M. A. "always agin" policy. A factual statement, issued by Dr. Edward J. McCormick, President of the A. M. A., pointing out that the *Star's* charges are not based on fact, was sent to that newspaper by the A. M. A. and published in the *Star* on February 12.

The Journal thought its readers would like to read these pieces since they reveal (1) that many editorial writers are not well informed on matters of this sort and (2) that the A. M. A. is "for" a lot more things than the public realizes.

Here is the editorial which appeared in the *Kansas City Star* (the reply statement of the A. M. A. follows editorial comment by the *Star*):

WHAT THE STAR SAID

We like doctors. We are very much against socialized medicine, just as they are. For the devotion to research and the great progress in medicine and extending the life span, we can't pay high enough tribute. But, frankly, we can't refrain from remarking that the American Medical association (A. M. A.) has about the most stupid and impossible public relations imaginable. It probably isn't intended. But whoever is setting up as a spokesman, supposedly for the doctors of the nation, is certainly inept, to put it in the most charitable fashion.

The public is getting the impression the A. M. A. is against almost everything under the sun. We don't believe doctors, as a rule, feel that way at all. Just recently the A. M. A. has taken on the veterans' organizations by campaigning against admittance to government hospitals of veterans with nonservice connected disabilities. It is feared this might open the door to socialized medicine. We are not quarreling so much with the soundness of the protest as the general effect flowing from it.

Most of the veterans' groups are sore as a boil at the A. M. A. and all needlessly. If there is an abuse it's one in which the veterans' groups should be consulted, with the Veterans Administration itself leading the cleanup if there is to be one.

President Eisenhower has even more recently put before the country a broad program extending not only social security but the health activities of the government to reach more millions. It explicitly emphasizes that it stops short of socialized medicine and that completely. It entails more government aid for hospitals and clinics, possible government reinsurance of private group hospitalization plans, especially those on the border line, to include the more needy.

The acclaim with which the A. M. A. spokesman received this program was so silent as to be almost vociferous in its implication. Even friendly members of Congress are asking just where the A. M. A. stands on this general welfare program and if it really represents the thinking of the average doctor. We don't believe it does. The height of absurdity has almost been reached when it has been suggested the A. M. A. favored the Bricker amendment to the Constitution, because the door might be opened to socialized medicine by some international agreement flowing from the United Nations. Or maybe the A. M. A. reached its "agin" peak when it opposed federal aid to medical schools and that when this whole country is in desperate need of doctors.

The sure and certain way to get socialized medicine is for the vocal leadership of the medical profession to become chronic "aginers." Just being against something doesn't stop it. We are going to progress in medicine and care of the people's health one way or another. It can and should be done short of socialized medicine and within the bounds of our private enterprise system. Doctors should take the lead. If it doesn't come that way, we will have socialized medicine, sure as fate. The whiskey and brewery interests opposed everything until we got the experiment in prohibition. Big business used to see a bogey man behind every move that represented progress until big business itself became the whipping boy of the politician and the demagogue. Business began to show sense. The bigger the business usually the harder the work on the problem of public relations now. It has changed the climate.

We are ready to believe that the impression being left by the A. M. A. spokesman comes from inexperience in the field of public relations more than intent. But there should be a quick shift from "agin everything" to lifting the banner high and spearheading the drive for carrying better health programs to more millions with the A. M. A. taking the lead. That's the way to stop socialized medicine. And we believe this reflects the real opinion of the great majority of our fine folks of medicine.

WHAT THE A.M.A. SAID

The American Medical Association has been under attack for many years by the proponents of government medicine. This attack has centered

on two points: (1) that the A. M. A. does not represent the true thinking of the rank and file doctors and (2) that the A. M. A. is a "standpat" organization which is "agin" all health progress. Both of these charges are false, but both were repeated in a *Kansas City Star* editorial on February 6.

Let me emphasize that the A. M. A. is a democratic organization. Its policies are decided by majority vote of a 190-man house of delegates, representing every state in the union and all the specialties and general practice. Missouri doctors not only are represented in this house, but have a member serving on the A. M. A. board of trustees.

In support of the second point *The Kansas City Star* characterized as "needless" the A. M. A.'s stand against the admittance of nonservice-connected cases to veterans hospitals. Particularly, it said this stand shouldn't have been taken without consultation with the V. A. and veterans' groups. The truth is that the A. M. A. has been meeting with these groups for over twenty years without solution of the problem. The veterans groups want more and more hospitals for veterans.

Doctors feel that sufficient V. A. hospitals have been constructed to care for all service-connected cases and see no reason why American taxpayers should finance the medical care of veterans whose illness has absolutely no connection with service. According to the V. A.'s own figures, such cases now total 65 per cent of the daily patient load in V. A. hospitals.

FOR ALL THE PEOPLE

Doctors are not against veterans; they are for all the people. We believe tax funds should be used to help build community hospitals, chronic disease centers and other medical facilities open to all the citizens of a community, including veterans. This is what President Eisenhower has proposed and we strongly endorse it. This stand does not make the A. M. A. popular with veterans groups, but we believe it has the support of the majority of citizens and will result in better care for all in the long run.

The editorial also criticized the A. M. A. for its supposed silence regarding President Eisenhower's health program. This is what the A. M. A. said in a nation-wide press release on January 24:

"The board is pleased to find so many of the ideas and principles for which the A. M. A. has striven for so many years. The board endorses the general objectives of the President to extend needed facilities, to promote further research, to increase coverage under voluntary health insurance and to rehabilitate the disabled."

The A. M. A. has reserved judgment on the proposal for federal government reinsurance of voluntary health insurance because to date this is just a vague idea. No specific bill has been presented. There is also serious question in the private insurance industry as to whether any such program is necessary since companies already reinsure each other.

ON HEALTH DEDUCTIONS

The A. M. A. has, however, taken a strong stand in favor of allowing all medical bills, including health insurance premiums to be deducted from taxable income. This would require no additional federal bureaucracy, and would help those who need help most—the people who have suffered a serious illness or injury within a given year.

The A. M. A. supports the principle of the Bricker amendment because there are at the present time several international agreements under study by the State department which would institute government medicine. These could be adopted by a two-thirds vote of the senators who happened to be sitting in the Senate chamber at any time and would supersede all previous decisions to the contrary. We favor an amendment which would insist that any treaty or executive agreement involving domestic law must be passed by both houses of Congress, as all our internal laws now are passed.

In a blanket manner, the editorial criticized the A. M. A.'s stand on federal aid to medical schools, implying A. M. A. was against training more doctors. The association is strongly in favor of expansion of our medical schools, and has demonstrated so repeatedly. The only question is how this can best be done.

AGAINST SCHOOL SUBSIDIES

A. M. A. has opposed yearly subsidies to medical schools because of the danger of federal control of educaiton. It has, however, supported one-time federal grants for the construction of medical school facilities, a proposal similar in nature to the Hill-Burton hospital construction act, which the A. M. A. has always endorsed. The American Medical Association is spending thousands of dollars annually through its council on medical education and hospitals to encourage the improvement and expansion of medical schools. In addition, it has established a nonprofit foundation to raise money for medical schools which has contributed $2,830,000 in the last four years.

The editorial seemed to imply that doctors public relations would be better if we were never "agin" anything. We do not believe our responsibility is to pose as Pollyannas. We believe our responsibility is to be honest with the people. This means pointing out dangers and opposing unsound measures as well as pushing many projects for improvement in the health field. While we say "bravo" many times, it is necessary to say "no" in a very definite manner on occasion. After



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all, seven out of the Ten Commandments begin with "Thou shalt not . . ."

We agree with *The Kansas City Star* that the A. M. A. should lift the banner high and spearhead the drive to carry better health to more millions. That is our aim. However, in the constant bombardment under which we have been working, it is often necessary to shore up our fortifications as well as lead the attack. Our job would be easier if we doctors were not subjected to the kind of uninformed heckling which appeared in *The Kansas City Star* editorial.

EDWARD J. MCCORMICK, M. D.
President, American Medical Association.

Evaluation of Foreign-Trained Doctor Rated as Major Problem

Licensure and medical care problems created by the heavy influx of foreign-trained doctors commanded a great deal of attention at the recent annual Congress on Medical Education and Licensure in Chicago.

"The infiltration of the medical profession of the United States by large numbers of doctors who have not been able to obtain a proper basic professional education is almost certain to lower the general level of practice in this country," Dr. Willard C. Rappleye, New York, dean of Columbia University College of Physicians and Surgeons, told the meeting. "The numbers coming in are so large that they cannot readily be absorbed without that effect."

Dr. Rappleye pointed out that the United States government, in fostering international good will, is admitting large numbers of displaced persons, including physicians about whose professional ability no questions are asked. More will be admitted by recent legislation which permits the entrance of several hundred thousands of immigrants above previous quotas, he said.

He added that unless this situation is met "with courage and the conviction that we shall not surrender the results of 40 years of effort in raising the standards of medical licensure, practice and education," we may revert to conditions resembling those of 50 years ago.

Dr. Stiles D. Ezell, Albany, secretary of the New York Board of Medical Examiners, said that except for Great Britain and the Scandinavian countries the last war brought destruction and degeneration to European medical education.

"Even before the elimination of the last of the unapproved medical schools in this country, there had begun a migration of physicians to this country which has now reached a total of more than 20,000," he stated. He pointed out that large numbers of foreign graduates have completed specialized training without any consideration of the deficiencies in their basic medical training or their eligibility for licensure.

Dr. Edward L. Turner, Chicago, secretary of the Council on Medical Education and Hospitals, recommended the adoption of a uniform plan for screening the professional competence of foreign-trained doctors.

This, Dr. Turner said, would be of greater assistance to state medical licensing boards than the present attempts to evaluate and list foreign medical schools. He pointed out that there are problems and difficulties in evaluating foreign medical schools which are "almost insurmountable."

Dr. Turner reported that the Council on Medical Education and Hospitals and the executive council of the Association of American Medical Colleges have compiled a list of 39 foreign schools which provide basic medical education on a par with that of approved schools in the United States, but said there are more than 550 medical schools in the world.

He said that while the council has endeavored to indicate that the absence of a school from this current listing does not indicate either approval or disapproval, but means primarily lack of adequate information, the absence of listing frequently serves to deny a graduate the right to examination before a state board.

Serious consideration should be given to the cooperative development of some commonly acceptable yardstick or screening mechanism to evaluate competence of the foreign graduate, Dr. Turner stated.

International College of Surgeons Announces Regional Meetings

The Northeastern Division of the United States Section of the International College of Surgeons will hold a meeting, sponsored by the New York State Surgical Division, in Poughkeepsie, New York, May 27 and 28 with headquarters at the Nelson House and scientific sessions at St. Francis Hospital.

The Rocky Mountain Division will sponsor a regional meeting in Salt Lake City, Utah, on July 22-23 with headquarters at Hotel Utah.

Additional information may be obtained from the International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

V. A. Juggles Millions of Indefinite Letters About Claims Monthly

Veterans Administration offices throughout the country are receiving an average of 10,500,000 pieces of mail monthly, about a million-and-a-half of which identify neither the veteran nor his claim. That means that 14 out of every 100 letters require tedious tracings through numerous files.

V. A. requests that every letter concerning a claim for benefit contain the full name and address, preferably printed or typewritten; service serial number; and claim number if one has been alloted.

Ohio State Expands Medical Program . . .

Teaching Facilities for Medical Students and Nurses Will Be Extended By Revamp of Outpatient Service and Additional Wing to Hospital Units

THE Board of Trustees of Ohio State University has announced two actions that will increase teaching facilities at the College of Medicine and provide additional services to patients.

The Board adopted a new scale of financial eligibility for those seeking outpatient services, which in effect will extend the outpatient department.

Expansion of the north wing of University Hospital to provide for housing diagnostic x-ray and classroom space, also was announced.

Two other announcements concerned remodeling of facilities for the University Health Service for students and receipt of a gift for a three-year research project on Hodgkin's disease.

OUTPATIENT SERVICE

The new scale of financial eligibility to be used as a basis for acceptance of patients replaces a standard established in 1922. Under the old schedule, a man and wife whose joint earnings were more than $200 a month, plus $25 for each dependent, could not receive treatment at the clinic.

The new scale, based on the Bureau of Labor Statistics Price Index, reflects changes in earning capacity and the value of money since 1922.

The new income limits for patients will be:

No. in Family	Income Before Taxes (Approx.)
1 person	$180 per mo.
2 persons	240
3 persons	300
4 persons	360
5 persons	390
6 persons	440

The board's action also declared that recognition should also be given to unusual situations, such as accumulated medical bills due to chronic illness and acute emergencies, and asked that a Social Service Division be created to facilitate classification of patients to be handled in the outpatient department under the new plan, with special reference to income levels and charges to be made.

Purpose of the recommendations, presented to the board by President Howard L. Bevis, was threefold:

To fulfill a plan for better teaching of more medical students and nurses; to increase the amount of clinical material available for teaching of enlarged senior medical classes; and to make essential medical services available to a large number of patients now neither eligible for clinics nor able to pay for private diagnostic treatment.

President Bevis told the board that the numbers of clinical patients treated in the hospital's outpatient department in recent years had not kept pace with teaching requirements. Size of the medical class admitted annually at Ohio State was increased from 84 to 150 several years ago.

BUILDING EXPANSION

Extension of the north wing of the University Hospital at Ohio State University to provide for housing diagnostic x-ray and classroom space was authorized on the recommendation of the University Cabinet, presented by Vice-President and Business Manager Jacob B. Taylor. The board authorized that a $500,000 appropriation enacted at the last session of the Ohio Legislature for "medicine-classroom facilities" be used for this enlarged purpose.

The board asked for further information on a request that consideration be given to still another extension of this north wing for the purpose of housing therapeutic x-ray.

PROJECT ON HODGKIN'S DISEASE

Ohio State University received a $90,000 gift from the Dorothy H. and Lewis Rosenstiel Foundation of New York City for a three-year research project on Hodgkin's disease, President Bevis informed the Board. The gift will be allocated to the College of Medicine in annual amounts of $30,000.

Dr. C. A. Doan, dean of the College of Medicine, who handled the negotiations with Mr. Rosenstiel said the gift "will actually underwrite and endow the work of the Herman A. Hoster Memorial Research floor in the new Cancer Research Wing of the University Hospital." The late Dr. Hoster, a member of the College of Medicine research staff, was himself a victim of Hodgkin's disease.

STUDENT HEALTH SERVICE

As this issue of *The Journal* went to press, plans were under way to move the University Health Service for students into the remodeled ground floor of the Student Services Building on the campus at 12th Avenue. The Health Service has occupied the east wing of Baker Hall for some years.

The new Ohio Union building facing High Street has made the old "Ohio Union" building, now known as the Student Services Building, available for other purposes. Other portions of the building will be occupied by other student personnel services after remodeling is completed.

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Reinsurance Proposal . . .

Sponsored by Eisenhower Administration Introduced in Senate and House; Bill Designed To Help Prepaid Medical Plans Meet "Abnormal" Losses

BILLS to carry out the Eisenhower administration's plan for reinsuring prepaid health insurance plans were introduced in House (H. R. 8356) and Senate (S. 3114) on March 11. In explaining the program, the Department of Health, Education, and Welfare, said:

"The program would not reinsure . . . a particular policyholder nor . . . a carrier as such. It would protect the carrier against bad experience in the aggregate under a particular reinsurance plan. Only abnormal losses and those in excess of anticipations would be reinsured . . . The carrier would share in paying these abnormal losses (U. S. share limited to 75 per cent) . . . The program is designed to encourage carriers to experiment more broadly and rapidly . . . Success would depend entirely on voluntary action by (carriers)."

NO ACTION BY A. M. A. AS YET

Up to the time this issue of *The Journal* went to press, the Board of Trustees of the American Medical Association had voiced no official policy regarding this proposal. The Board has stated that it intends to analyze the proposal carefully before announcing its opinion.

The program would be started with a federal appropriation of $25 million. The objective is to make the fund self-sustaining within five years by scaling premiums to match expenses, with the U. S. advance to be repaid. The federal obligation would not extend beyond the money in the reinsurance fund, or in separate funds if they are established.

Responsibility for administration would rest with the Secretary of H. E. W., who would also fix rates of reinsurance and could cancel contracts for cause. State insurance authorities would be used to the maximum extent, including enforcement of compliance with regulations.

Plans Eligible: Private insurance companies, voluntary nonprofit associations such as Blue Cross and Blue Shield, and other voluntary groups could participate if approved by the Secretary and if they complied with conditions and standards, including those noted below.

Required of Plans: The Secretary would establish terms, conditions and requirements for types of plans, taking into consideration these objectives: extension of coverage to persons not now protected, extension to new geographic areas and provision of benefits and services not now readily available. Plans would not be approved unless (a) financially sound, (b) operating according to state law, and (c) worthy of public confidence. The Secretary would specify minimum benefits and waiting periods, and set up safeguards against undue exclusions based on such things as preexisting conditions and specific illnesses. Plans of a given kind or type could be reinsured only if reinsurance, on comparable terms and conditions, were not available from private sources.

Federal Council and Technical Service: A National Advisory Council on Health Service would be established, consisting of 12 members four of whom would have to be experienced in the administration of health plans. Appointments would be by the Secretary. The Council would advise, consult with and make recommendations to the Secretary. The Department of H. E. W. also would maintain a technical advisory and informational service to assist health plans without cost. The information service would conduct studies and collect and distribute information on the organizational, actuarial, and other problems of health insurance.

PROPOSED NEW FORMULA FOR GRANTS

One of the main points in the Eisenhower Administration's health program is a proposal to establish new methods of distributing grants-in-aid for state and local public health activities. Recently, Mrs. Hobby, Secretary of Health, Education, and Welfare, appeared before the House Committee on Interstate and Foreign Commerce in support of H. R. 7397 which would accomplish that purpose. Following is a report on Mrs. Hobby's testimony before the committee, inserted in the Congressional Record by Congressman Wolverton, in which she analyzes the bill and explains its purposes:

SECRETARY'S TESTIMONY

Mrs. Hobby explained to the committee that the bill is designed to simplify and improve the several grant-in-aid programs which are now administered pursuant to the provisions of the Public Health Service Act. She pointed out that there are 14 major grant-in-aid programs administered by the Department of Health, Education, and Welfare. Of these 14, six are for the support of State and local health services. The provisions of H. R. 7397 apply only to this latter group.

The bill would replace the present separate authorizations for categorical public health grants for venereal disease control, tuberculosis con-

trol, general health and heart disease control—including the separate programs for mental health and cancer control—with an authorization for the following three types of grants:

First, Grants to assist States generally in meeting the costs of their public health services.

Second, Grants to assist States in initiating extensions of, and improvements in, their public health services.

Third, Grants to assist in meeting the costs of projects directed toward the solution of public health problems of regional or national significance.

The amount of Federal funds to be available for each of the above three types of grants would be specified in annual appropriation acts.

GENERAL GRANTS

The formula for determining each State's allotment for the first type of grant would be the same as that used in the hospital survey and construction—Hill-Burton—provisions of the Public Health Service Act—which take into account both the relative populations of the States and their relative fiscal resources as measured by State per capita incomes. There would, however, be a minimum allotment of $55,000. From its allotment, each State would receive payments equal to a percentage of the cost of public health services under its approved State plan, the percentage varying inversely with the State's relative per capita income between a maximum of 66-2/3 and a minimum of 33-1/3 per cent. This contrasts with present law under which the amount of the allotment and the Federal share of the cost are determined by regulations and differ from program to program.

EXTENSION AND IMPROVEMENT GRANTS

The formula for determining each State's allotment for extension and improvement purposes would be based on relative State populations with a minimum allotment of $25,000. From its allotment, a State could receive, over a 6-year period, varying proportions of the cost of approved projects—included in its approved State plan—for extension and improvement of its public health services—75 per cent of the cost for the first 2 years, 50 per cent for the next 2, and 25 per cent for the last 2.

SPECIAL PROJECT GRANTS

These grants would be made on a project basis to States and to public and nonprofit agencies or organizations. They would be available for paying part of the cost of combating unusually severe public health problems in specific geographical areas, and of carrying out special projects which hold unique promise of contributing to the solution of public health problems common to all or several States, and projects directed at meeting public health problems of special national significance or concern.

STATE PLANS

Payments from allotments for the first type of grant—for support of public health services—would be conditioned upon submission of a plan by the State health authority—and mental health authority in connection with mental health—which meets requirements prescribed in regulations of the Surgeon General.

As under existing law, regulations would be issued by the Surgeon General, subject to the approval of the Secretary of Health, Education, and Welfare, and only after consultation with and, insofar as practicable, the concurrence of the State Health—or mental health—authorities.

ADMINISTRATION

The grants would continue, as under existing law, to be administered through the Public Health Service of the Department of Health, Education, and Welfare.

TRANSITION PROVISIONS

In order to provide states an opportunity to adjust their finances to the new allotment formulas, provision would be made to limit to 10 per cent any decrease in allotments which any State would receive in any 1 year by virtue of the formula change.

Mrs. Hobby testified that when she first examined the present grant structure, it became apparent that the number, variation, and complexity of existing authorizations and regulations were obstacles to effective administration, particularly State and local administration. Further, it appeared that the pattern and structure of these grants did not provide the flexibility needed to meet the problems of the several States in the best possible way. She stated further that last year she reviewed the history and operation of all these programs and came to the conclusion that there is a real need for clarification, greater flexibility, and more local determination in connection with administering the program. Consequently, legislation was developed and designed to accomplish these objectives.

These amendments to the Public Health Service Act would not become effective until July 1, 1955.

BRICKER AMENDMENT

The proposed constitutional amendment limiting the power of the President to make international agreements may be reconsidered by the Senate, following its one-vote failure to pass the Senate on February 26.

Several days later, Senator Lennon (D., N. C.), who was not present for final voting but who was reported in favor of an amendment, filed a motion to reconsider the February 26 action. This means that his motion can be brought up

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at any time during the remainder of this session by a simple majority and should it pass, then full debate would be resumed on the George amendment and an opportunity offered Senators to change their votes.

NEW HILL-BURTON EXPANSION BILL

The House Interstate and Foreign Commerce Committee on March 3 favorably reported a new bill (H. R. 8149) for expanding the Hill-Burton hospital construction program to include diagnostic or treatment centers, hospitals for the chronically ill, rehabilitation centers and nursing homes. Later, it was passed by the House.

The same appropriations are asked: $182 million over three years, with $2 million for planning and surveys, $20 million annually for diagnostic or treatment centers, a like amount for hospitals for the chronically ill, $10 million for rehabilitation facilities and a like amount for nursing homes. Administration would be by states, under regulations drawn up by the U. S. Surgeon General. The changes include:

U. S. Share. The new bill adopts the regular Hill-Burton procedure for matching, except that a state may decide on a 50-50 matching program.

". . . For All the People." The new bill restates the purpose of the original Hill-Burton law to help states to provide facilities "for furnishing to all their people adequate services." It is understood that this would rule out facilities sponsored by a labor or fraternal organization or a prepaid health plan unless the general public were allowed full and unrestricted use of the facilities.

'Nonprofit' and 'Public' Requirements. The first bill limited grants to "nonprofit" centers or hospitals. The second changes this to read "public and other nonprofit" centers or hospitals. The earlier bill required that centers and nursing homes be "under the professional supervision of persons licensed to practice medicine in the state." The second broadens this by also making eligible centers and nursing homes that are "operated in connection with a hospital."

Restriction on Diagnostic-Treatment Centers. A new restriction is written into the bill concerning diagnostic or treatment centers. If they are not public, they would have to be operated by or be a part of "a corporation or association which owns and operates a nonprofit hospital." This would bar U. S. grants to a group of physicians who want to set up a center, unless they also operate a nonprofit hospital.

Bi-State Facilities. Under the new bill it would be possible for a state to have a portion of its allocation transferred to another state to help in the construction of a facility for use of both states.

Restriction on Disposition. The first bill would have authorized the federal government to recover its proportionate share of a facility converted to private-profit use within 20 years after construction. The new bill would allow the U. S. to recover if the facility were sold or transferred at any time.

ORAL NARCOTIC PRESCRIPTIONS

H. R. 7817 would permit the sale of narcotic drugs that possess little or no addiction in comparison with morphine, codeine, or cocaine on an oral prescription of a registered physician, dentist, veterinary surgeon, or other authorized practitioner.

The oral prescription must be put in writing promptly and filed with the druggist or dealer. In issuing an oral prescription, the same information as is now required on written prescriptions would be necessary.

The determination of what narcotic drugs could be prescribed orally is left to the discretion of the Secretary of the Treasury. He is to consider the views of the Public Health Service, the Food and Drug Administration, and the secretaries of national associations representing physicians, pharmacists, and narcotic drug manufacturers. The bill is supported by the National Association of Retail Druggists.

MISCELLANEOUS

The House Labor Committee has ordered an investigation of racketeering in the administration of labor union welfare funds. A few days before the forced resignation of Clarence Manion as chairman of the Commission on Intergovernmental Relations, it was learned that the commission would be granted another year in which to complete its work. It had been scheduled to finish its task by March 1. A special House committee has been authorized by President Eisenhower to examine tax returns filed by various organizations claiming tax exemption as nonprofit . . .

President Eisenhower has announced that later in the session Congress will be asked to set up a program of contributory medical care and hospitalization insurance open to all federal employees, and supported in part by an annual contribution of about $50 million from the U. S. government. Payroll deductions would be authorized. The plan is reported to include these other points: The government and the employee to share equally premium costs up to $25 per year per employee, with the latter paying all costs above that figure. The employee would have his choice of hospitalization, surgical care and medical care, or all three, for himself and his family, but the U. S. contribution would not exceed $12.50. Private insurance groups—Blue Cross and Blue Shield, White Cross, and co-operative group health plans—would handle the insurance. There would be no set formula, but details would vary among departments and geographic areas.

Is It Lawful? . . .

Legal Authority for Physical Examinations, Treatments, Operations, Etc., Discussed; How To Secure Consent and From Whom; Other Warnings

IS it necessary for a physician to secure authorization of physical examinations, treatments, operations and autopsies?

If so, from whom? In what form? What constitutes lawful authority?

These are some of the questions often asked by a physician of himself, or someone else, as he pursues his daily practice. Obviously, the answers are of great importance to him.

One of the most complete papers on this general subject is that published some years ago by William C. Woodward, M. D., and LL. M., who, at that time, was director of the Bureau of Legal Medicine and Legislation of the American Medical Association.

Since the Columbus Office of the Ohio State Medical Association has received several questions on this general subject, recently, *The Journal* believes that certain excerpts from Dr. Woodward's paper will be of interest and value to all members of the Association.

In the following comments, Dr. Woodward used the term "operation" to cover examinations and treatments as well as operations. You will note particularly his advice that physicians seek competent legal advice when in doubt or where a dispute arises.

LAWFUL AUTHORITY REQUIRED

A physical examination of a patient cannot be made or an operation done, lawfully, without authority. Authority is necessary, too, before a physician can lawfully apply to a patient any prophylactic, diagnostic or therapeutic agent, such as a vaccine, a splint, roentgen rays, or an anesthetic or any other drug. A person who does any of these acts without authority commits a battery or a trespass, or both, for which, according to the circumstances of the case, he may be fined or imprisoned or made to pay damages. Even after the death of a patient his right to freedom from interference automatically passes in a modified form to his spouse or to his next of kin, and any unauthorized interference with his dead body exposes the offender to a suit for damages by the person entitled to its custody.

The principles governing the authorization of physical examinations, operations and treatment are identical. The term "operation" is used, therefore, throughout this discussion, for the sake of brevity, to cover all of them. While the principles stated are of general application throughout the United States, it must be understood that in some states they may be modified by statute or by court decision, and in case of doubt and dispute the physician will do well to take the advice of competent counsel before he proceeds.

LAWFUL AUTHORITY DEFINED

Lawful authority for the physical examination of a patient, an operation or local treatment arises only (1) out of a legal duty or (2) out of the consent of the patient or some one authorized to act on his behalf.

In the everyday practice of medicine, lawful authority for the physical examination of a patient, an operation or treatment is nothing more than valid consent. Consent, however, even by the patient himself, is not necessarily valid. Consent may be invalid (1) because it undertakes to authorize an unlawful act or an act contrary to public policy, or (2) because it comes from a person who has no lawful right to give consent, or (3) because it was obtained by misrepresentation or fraud.

FORM OF CONSENT

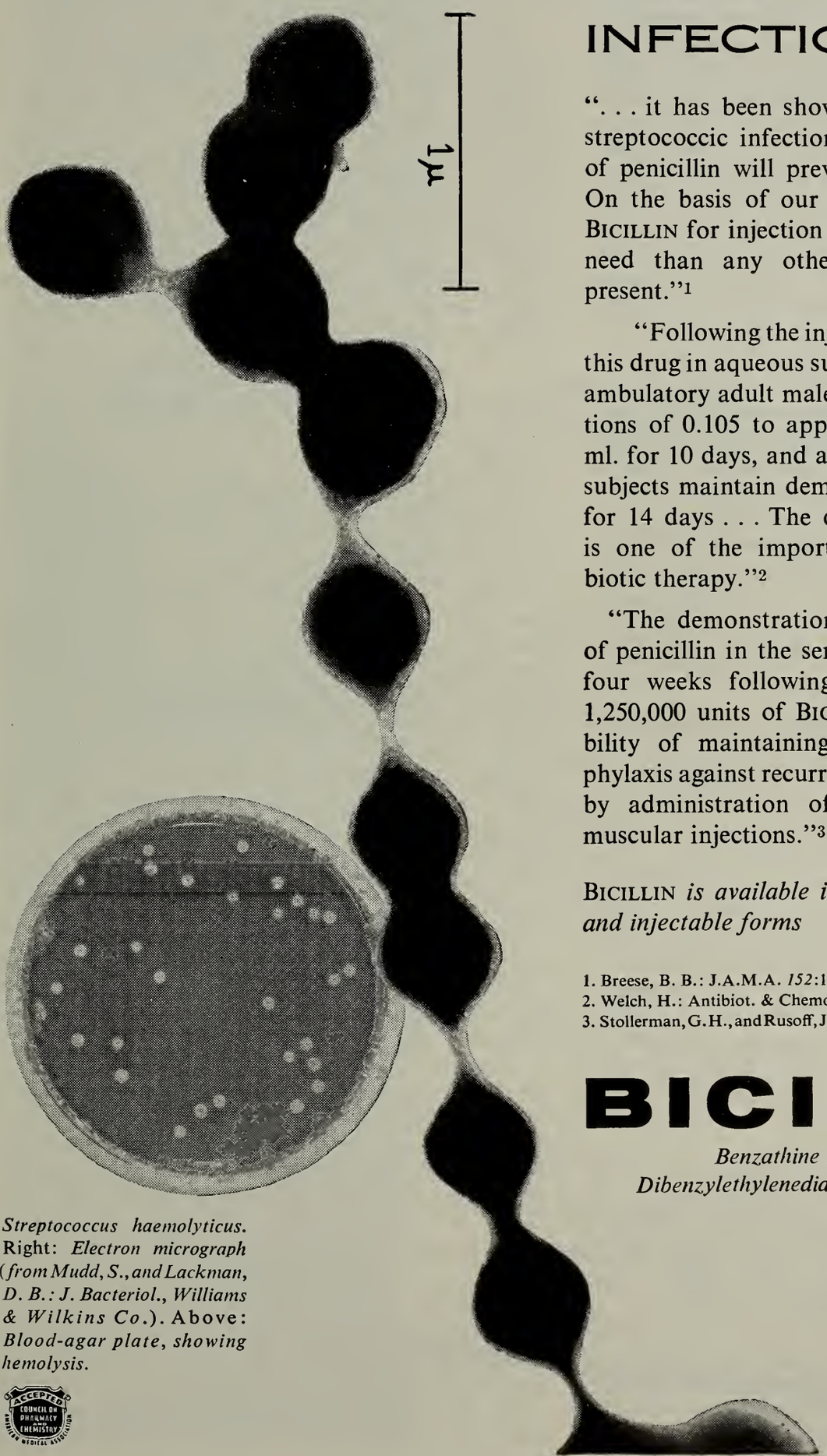
Consent to an operation or an autopsy may (1) be implied by the circumstances of the case or (2) be given by word of mouth or (3) be given in writing. All forms of consent are equally binding, but consent should be in writing, if possible, in order to avoid misunderstanding and to facilitate proof of consent.

IMPLIED CONSENT

"Actions speak louder than words." When a patient of mature years and sound mind, who knows that he is at liberty to submit or to refuse to submit to an examination, operation or treatment, knows or is fully and fairly informed by his physician as to an examination, an operation or treatment that is to be undertaken and then cooperates with the physician in bringing it about, he has impliedly consented to it, even though he has not consented in words. Such implied consent is the consent customarily given in everyday practice, especially with reference to minor activities. It is less common with respect to autopsies, although the same principle applies; that is, if the person lawfully having custody of the body, authorized to say whether an autopsy may or may not be performed, and having a knowledge of his rights, cooperates in bringing about the performance of the autopsy or stands by and sees it performed, he impliedly consents to it. Implied consent to operations and to autopsies, however, always carries with it the possibility of misunderstanding as to the purpose and scope of the understanding and of difficulty of proof in case of controversy.

It is under the legal concept of implied consent

SUSTAINED PENICILLIN LEVELS IN STREPTOCOCCAL INFECTIONS



Streptococcus haemolyticus. Right: *Electron micrograph (from Mudd, S., and Lackman, D. B.: J. Bacteriol., Williams & Wilkins Co.).* Above: *Blood-agar plate, showing hemolysis.*

"... it has been shown that the treatment of streptococcic infections by adequate amounts of penicillin will prevent rheumatic fever ... On the basis of our experience, we feel that BICILLIN for injection more nearly supplies the need than any other product available at present."[1]

"Following the injection of 600,000 units of this drug in aqueous suspension, 100 per cent of ambulatory adult males show blood concentrations of 0.105 to approximately 0.03 unit per ml. for 10 days, and about 50 per cent of these subjects maintain demonstrable concentrations for 14 days ... The development of BICILLIN is one of the important milestones in antibiotic therapy."[2]

"The demonstration of detectable amounts of penicillin in the serum of most patients for four weeks following the administration of 1,250,000 units of BICILLIN suggests the feasibility of maintaining continuous drug prophylaxis against recurrences [of rheumatic fever] by administration of single monthly intramuscular injections."[3]

BICILLIN *is available in oral suspension, tablet, and injectable forms*

1. Breese, B. B.: J.A.M.A. *152*:10 (May 2) 1953
2. Welch, H.: Antibiot. & Chemo. *3*:347 (April) 1953
3. Stollerman, G.H., and Rusoff, J.H.: J.A.M.A. *150*:1571 (Dec. 20) 1952

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Benzathine Penicillin G
Dibenzylethylenediamine Dipenicillin G

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that a physician is permitted in an emergency to operate on a delirious or unconscious person who is unable to determine for himself whether an operation shall or shall not be done. Such a situation frequently arises in connection with serious accidents. Of course, if any one having authority to act for the mentally incompetent person is present, or if, without jeopardizing the welfare of the patient, any such person can be communicated with before operating, consent should be obtained in the usual manner. As has been pointed out, the absence of such consent need not deter a physician from proceeding with the operation, for the law presumes that a person mentally incapacitated consents to having done for him what is in his own interest; and if an operation is in the interest of the patient, the consent of the patient is implied. While the consent of kin and relatives of a patient, other than the parents of a minor child, and the consent of friends of the patient, are of value in supporting the judgment of the physician, such kin, relatives and friends have no legal right to act for the unconscious patient. Their authority is no greater than that of the attending physician, and their responsibility is much less. The physician may find it necessary, therefore, to act on the basis of his own judgment, even contrary to what kin, relatives other than the parents of a minor child, and friends of the patient advise. He must be prepared, however, to justify his course, in court, if it is called into question.

ORAL CONSENT

Consent by word of mouth to an operation or an autopsy is probably the most common form of consent. Ordinarily it is supplemented by implied consent; for instance, a patient, after orally consenting to an operation, cooperates with the physician in its performance. Oral consent is, however, open to misunderstanding and may be difficult of proof. Whenever it is to be relied on, an effort should be made to make the entire situation and proposed operation as clear as possible to the person whose consent is sought, and consent should be given in unequivocal terms. If these precautions are taken in the presence of one or more disinterested witnesses, there is little likelihood of trouble and if trouble comes the physician will have an adequate defense.

WRITTEN CONSENT

Written consent to an operation or to an autopsy is by far the safest, for it permits a clear record of the nature and extent of the operation or autopsy that is authorized. Written consent, as a condition precedent to an operation or an autopsy, is more easily required by a hospital than by a private practitioner, for the relations between a hospital and the patients in it are more impersonal than are corresponding relations in private practice. Nevertheless, in view of the modern tendency toward depersonalization in the relations between physician and patient even in private practice, written consent should be obtained in all cases if possible.

No particular form is necessary to give validity to written consent to an operation or an autopsy. The essential requirements are that it state clearly the nature and extent of the operation or autopsy that is authorized and that it be signed by a person legally qualified to give consent. The inclusion of the place and date of execution and the signature of a witness are desirable, but only because they tend to facilitate proof. Any paper-writing purporting to give consent to an operation or an autopsy should be preserved not only until the completion of the operation or the autopsy but for a period thereafter sufficient to cover the entire time within which, under the statute of limitations of the state, a suit may be instituted.

POSTMORTEM CESAREAN SECTIONS

The authority and duty of a physician in attendance at the death of a woman who has within her body at the time of death a living viable child have not been defined by statute or court decision. A surviving husband, if there is one, ordinarily has a legal right to the custody of the body of his deceased wife in the condition in which it was when she died and the body cannot be lawfully mutilated in any way without his consent. Presumably he has, too, certain legal authority and responsibility with respect to his unborn living child. But the idea that a surviving husband can lawfully kill his unborn child, in the body of his deceased wife, by withholding his consent to the simple procedure that would save the child's life, is unthinkable. While the consent of the surviving husband should be obtained therefore, if practicable, before delivering a living, viable unborn child by postmortem cesarean section, a physician can probably with impunity perform the operation without that consent and even against the surviving husband's wishes if there is reasonable belief that thereby the life of the child will be saved. Whatever the legal, technical rights and wrongs of such procedure may be, it is impossible to conceive of any ground on which the surviving husband could claim substantial damages—if he could claim any—on the ground that the body of his dead wife had been operated on without his consent in order to preserve the life of his child.

INSTRUCTIONS CONCERNING CONSENT TO OPERATION

(a) While written consent to operation is not necessary, it is desirable that consent should be in writing in order to avoid misunderstandings and to facilitate proof of consent.

(b) The consent of the patient is necessary and is sufficient to authorize any lawful opera-

Widely prescribed

A THERAPY THAT EMBRACES
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THE ENTIRE ALKALOIDS
OF STRAMONIUM



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SEQUELAE
OF
EPIDEMIC
ENCEPHALITIS

STRAMONIUM PILLS

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O.15 GRAM (APPROX. 2½ GRAINS)

These pills exhibit the powdered dried leaf and flowering top of Datura Stramonium, alkaloidally assayed and standardized, and therefore contain in each pill 0.375 mg. (1/170 grain) of the alkaloids of stramonium.

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tion, if he (1) has attained his majority and (2) is at the time of giving consent competent to understand the nature and purpose of the operation proposed and the risks involved, and (3) does in fact understand the nature, purpose and risks of the proposed operation.

(c) It has been held that the consent of the husband to an operation on his wife is not necessary if the operation is necessary to the health and life of the patient and the patient herself consents to it. It is nevertheless advisable to have the spouse join in consent whenever practicable. It is particularly important to do so if the operation involves danger to life or may destroy or limit sex functions or may result in the death of an unborn child. Probably the consent of the husband is not necessary to validate consent given by his wife for an operation on herself that is not necessary for her health but is to be done only for cosmetic purposes. If, however, it is proposed to charge to the husband the cost of a purely cosmetic operation, it will be well to obtain his consent before the operation, so that he cannot later repudiate his liability on the plea that the operation was not legally a necessity for which his wife was entitled to pledge his credit.

(d) If the patient is a minor, authority for an operation must come from his parent or guardian. A man, and in many states a woman also, attains his or her majority on the day preceding his twenty-first birthday. In some states a woman attains her majority on the day preceding her eighteenth birthday. In some, the marriage of a person who is a minor "emancipates" him or her from parental control and may raise a question as to his or her relative rights with respect to an operation in relation to the rights of parents and spouse; but such a question can be settled only by competent legal authority.

INCOMPETENT PATIENT

(e) If the patient is of unsound mind and incompetent to understand the nature and purpose of the proposed operation and the risks incident to it, authority for the operation must come, (1) if he is a minor, from one or both of his parents, unless a guardian has been appointed for him by the court, in which case it must come from his guardian, and, (2) if he has attained his majority, from his legally appointed guardian. Although in the case of a minor of unsound mind the consent of the father may ordinarily be looked on as sufficient, or, if the father is dead, the consent of the mother (unless, as has been suggested, the court has appointed a guardian for the minor) it may be well to err on the side of safety and obtain the consent of both father and mother. This is particularly true if there are evidences of any lack of agreement between them as to consent to the operation.

(f) When an immediate operation is imperative, and when the patient's mental state, because of his ordinary mental incompetence or because of acute injury or disease, is such that he cannot rationally consent to a proposed operation, and when such delay as would be necessarily incident to obtaining the consent of the parent or guardian involves serious risk to the patient, an operation may be performed on the basis of the legal theory of implied consent. The law implies in any such case that the patient, if competent, would consent to whatever may be in his own interests. When a surgeon operates under such circumstances, however, he should be prepared to show, if the issue is raised in the course of litigation, (1) that an immediate operation was necessary, (2) that a lawful express consent could not be obtained from the patient or from any person authorized to act for him, without endangering the health or life of the patient, and (3) that the operation performed was only such as was necessary for the patient's welfare.

UNFORESEEN PROCEDURE

(g) If the patient who is being operated on has consented only to a specifically limited operation, and if in the course of the operation it becomes necessary for the patient's representative, authorized for that purpose, to give or to refuse consent to an enlarged or different operation, the consent of that representative should be obtained before proceeding beyond the prescribed limits; unless an emergency requires the operation to proceed beyond those limits before obtaining consent. Ordinarily, it should be sufficient to obtain the oral consent of the patient's agent for the enlarged or different operation, without delaying the operation, and at the close of the operation obtain that agent's signature to a written consent showing with reasonable certainty the nature and extent of the auxiliary operation authorized by him. If the patient's agent refuses to consent to an auxiliary operation advised by the operating surgeon, the operation should be brought to an end, unless it would jeopardize the life of the patient to do so. In that case the operating surgeon should assume personal responsibility for proceeding. In any event, the refusal of the patient's agent to consent to the operation, if he does refuse, should be reduced to writing at once.

(h) If the operation to be performed is of minor importance and to be performed without the use of a general anesthetic or of spinal anesthesia, the record of the names and addresses of persons who may properly be notified in event of death or unexpectedly prolonged unconsciousness may be omitted. It may be omitted, too, if it is already of record in the files or case history or if it is already known to the physician in charge of the case or by the officers of the institution in which the operation is to be performed.

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WERE YOU A GOOD CITIZEN OR A POOR ONE?

Election statisticians have figured out that in most counties of Ohio the greatest number of votes cast for or against any one of the nine issues on the ballot at the last November elections was less than half of the total number of eligible voters of the county.

People either "didn't know"; "didn't care"; being doubtful, voted "no"; just "didn't vote"; or didn't show up at the polls.

Not too good a picture of the interest of a good many Ohioans in governmental affairs. In fact, it's rather tragic.

In a recent issue, *American Mercury* reported on government spending during the 20 years just ended.

In those 20 years, the government spent more that $775,000,000,000 and ran up a net deficit of more than $239,000,000,000. In other words, it spent almost half again as much as it was able to collect, despite ever-increasing taxes.

At the end of fiscal 1933, the national debt amounted to a fraction less than $180 for each American. Now the figure is above $2,000.

In 1933, a typical family with a $4,000 a year income paid $44 in federal income taxes—now it must pay close to $500.

In the last fiscal year, tax collections were 2,100 per cent greater than in 1933.

Isn't it about time that all citizens— including physicians—take a greater interest in their local-state and federal governments? Any time there is an election, citizens are affected. Good citizens are those who get the facts and then vote—yes or no as their judgment dictates.

Remember the Primary Election May 4. Here's your opportunity to exercise the primary requisite of good citizenship—your vote.

GETTING DOCTOR FOR EVERY AREA NOT AN EASY PROBLEM

The old problem of proper and logical distribution of physicians is gradually being licked. Figures issued by Frank G. Dickinson, director of the Bureau of Medical Economic Research of the A. M. A. support this.

Dickinson reports that every town in the country with a population of more than 5,000 had at least one physician in active practice, as had 96 per cent of those with a population between 2,500 and 5,000; 88.3 per cent of those with a population of between 1,000 and 2,500, and 21 per cent of those with a population between 100 and 1,000. More than half of the latter group had less than 250 inhabitants. Only one-sixth of one per cent of the population lived outside a 25-mile radius of the closest town with a physician in active practice, he said.

Obviously, there still are small outlying areas which are seeking physicians. They used to have a physician. They want one now. Unfortunately, the trend of the times is not on their side. Modern transportation and other economic and social changes have changed the picture. Those areas are going to have to look to larger adjacent centers, undoubtedly, for their medical services of the future.

The Physicians Placement Service of the Ohio State Medical Association is doing everything within its power to encourage physicians to locate in all of the communities listed as needing, or wanting, a physician. It will continue to do so. Nevertheless, the practical problem which confronts many of the smaller communities must be looked at in a realistic way. The odds are against many of them.

PHYSICIAN AN IMPORTANT COG IN O. M. I. PROGRAM

An excellent series of articles regarding Ohio Medical Indemnity, Inc., the prepaid medical care plan sponsored by the Ohio State Medical Association, has been appearing in the *Montgomery County Medical Society Bulletin.* They have been authored by Dr. R. Dean Dooley, Dayton, a member of the Board of Directors of O. M. I.

In his closing article, Dr. Dooley made the following statement which contains a heap of sound advice and, if followed by all physicians, would eliminate most of the problems which confront O. M. I. and minimize much of the criticism on the part of some O. M. I. subscribers:

"The doctor," said Dr. Dooley, "can be the most important cog in maintaining good relations between the subscriber, the insurance company and the physician. Too much emphasis cannot be placed on the importance of discussing charges before procedure is carried out. The method of approaching the discussion is also of prime importance. The method of discussing fees assumes greater significance in the face of charges leveled at the medical profession by top labor leaders since the claim is made that the volunteer medical plans fail because physicians use the insurance benefit as a plateau on which the charge is made. They allege that the doctor adds his regular fee to the amount of

the indemnity and that the patient thereby receives no aid at all from his insurance.

"This charge has been made publicly within the last few days. To avoid any suspicion that this is being done the charges should be discussed and agreed upon before the patient is asked whether or not he has insurance. By doing this there can be no question of the physician's motive. It can then be explained to him that his contract allows an amount for the operation and the difference between that amount and the charges agreed upon must be paid by the patient. If this is done many of the complaints will be eliminated; the patient, his insurance company and the doctor will all remain on better terms.

"O. M. I. is trying to do a good job by supplying insurance at reasonable rates. It can be made a much more effective instrument if it receives the wholehearted cooperation and support of the physicians in Ohio."

GOOD ADVICE FROM CLEVELAND ETHICS COMMITTEE

The well-known slogan of the Better Business Bureaus—"Before You Invest, Investigate"—is recommended, in effect, in a warning recently issued to members of the Cleveland Academy of Medicine by the Academy Ethics Committee. In addition the committee places some definite interpretations on certain ethical principles with which physicians should be familiar. If the advice is good in Cleveland—and it is—then it should be heeded by any physician any place. Here is what the Cleveland Academy committee told the Academy membership:

"The question of the propriety of newspaper publicity and paid advertising is repeatedly raised and many physicians have properly sought the advice of the Ethics Committee before inserting such ads, or news stories. Not infrequently the matter comes to the attention of the Committee only when someone complains. Investigation of the cause of these complaints almost invariably yields the information that the story was printed without the knowledge of the physician or because of his lack of familiarity with local custom.

"Ethical practice with regard to paid advertising and newspaper stories varies in different parts of the country. Physicians from other localities or from foreign countries are understandably unfamiliar with local customs. Because of this variation, the local medical society must be the arbiter of such matters, and this is one of the functions of the Board of Directors of the Academy of Medicine, exercised through the Committee on Ethics.

"The Committee takes this opportunity of reviewing the position of the Academy with reference to publicity in general, in hopes of forestalling future complaints.

"In Cuyahoga County it is considered improper for any physician to insert a paid advertisement in any publication, radio, or television program, indicating the opening of an office, change of address, office hours, type of practice, or other change of status. It is also considered improper for similar information to be included among lists of occupants of new or renovated buildings, either as an advertisement or as a news story. The opening of such a building is a legitimate news item in neighborhood publications, but details that will be of direct advantage to the physician have no place in such stories.

"The propriety of newspaper, radio, or television releases dealing with physicians is frequently difficult to assess. The Committee, when consulted, must decide each case on its merits, and when in doubt has the privilege and obligation to refer the matter to the Board of Directors. In making such decisions certain broad principles are considered.

"Feature stories concerning the participation of physicians in scientific or social advances and achievements either for the good of society or the medical profession are in the public interest, and are therefore considered proper.

"If the association of a physician's name in a story does not aggrandize him in his practice, such association is considered ethical.

"Since it is impossible to draw clear lines of propriety in many instances physicians are invited and urged to consult with the Ethics Committee before participating in such ventures. Acceptance or rejection of the proposed publicity by the Committee constitutes a protection to the physician."

PAMPHLETS HELP BUT AREN'T THE ANSWER

Public Relations Bulletin of the Medical Society of the State of Pennsylvania says: "Complaints against medicine generally start at the local level, spread to the state level, and finally become national issues. The logical place to commence an offensive campaign therefore is at the local level and not at the state or national level . . . There's nothing wrong with medical public relations which good professional relations in the first instance can't cure."

Another way of saying, Doctor, that public relations, good or bad, start at the level of the doctor's office.

Sure, our Columbus Office has scads of folders on p. r. hunches and techniques for physicians and will be glad to mail them out. But, in a way, isn't that locking the barn door after . . . ?

LET YOUR CONGRESSMAN KNOW YOUR VIEWS ON S. S. COVERAGE

Strong protests against compulsory Old Age and Survivors Insurance coverage for physicians in the Federal Social Security Program have been made by the American Medical Association which believes that most physicians do not favor compulsory participation for themselves. The A. M. A. at the same time is sponsoring legislation which would encourage physicians to provide retirement insurance on a voluntary basis by granting them the right to deduct part of premiums paid for voluntary retirement insurance as an expense in filing income tax returns. (Keogh-Jenkins Bill.)

The Council of the Ohio State Medical Asso-

ciation has taken a similar position and has suggested that all physicians who agree, should immediately make known their opinions to Ohio Congressmen.

Few physicians retire from active practice at age 65; few want to do so. Under the present law, and if physicians are included in coverage, many physicians probably never would benefit, or, if at all, only partially. Moreover, physicians are not subject to employment policies which may make retirement compulsory at a given age —say, 65. The S. S. law was designed especially to protect persons working for others and therefore subject to management policy on employment.

Think it over; then send your views to your Congressman.

MEDICAL GRADS NEED PRACTICAL ADVICE

News reports on the recent Congress on Medical Education and Hospitals in Chicago state that a panel discussion on professional orientation brought the general agreement that most medical school graduates enter active practice with inadequate preparation and training in ethics, medical economics, doctor-patient relationships and social problems.

In our opinion it is high time that something be done to change this situation, if true. Obviously the officials of medical schools, with the help of individual physicians and medical societies, are the ones who have to face this challenge. Don't blame the medical graduate. We believe that most medical schools are endeavoring to meet their responsibilities in this field but perhaps they are giving proper instruction on such matters too low a priority.

So far as Ohio is concerned—the services of the Ohio Medical Association in providing speakers and material on the subjects mentioned are available to Ohio's three medical schools, for the asking.

Medical Board Report for 1953

Dr. H. M. Platter, secretary of the State Medical Board in his annual report for 1953, stated that during the year the Board licensed 350 doctors of medicine on examination; 376 doctors of medicine on endorsement from other states; 65 doctors of osteopathy on examination; 19 doctors of osteopathy on endorsement; and 138 limited practitioners on examination. The report also pointed out that the Board's two inspectors investigated 186 complaints of illegal practice. Thirty cases were filed in court; one case was dismissed; 15 cases are awaiting trial; and five pending cases were concluded. Cases in which convictions were obtained during the year totaled 21.

What To Write for

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

The Home Buyer's Check List. Points out over a hundred features to consider, and includes system of rating. Available for 25 cents from Southwest Research Institute, 8500 Culebra Rd., San Antonio 6, Texas.

Facts About Color TV. How soon and probable costs. Available free from National Better Business Bureau, Chrysler Bldg., New York 17.

Rehabilitation Centers in the United States. Descriptions and statistics regarding rehabilitation procedure as discussed at First National Conference on Rehabilitation Centers, held December, 1952. Available from National Society for Crippled Children and Adults, 11 South LaSalle St., Chicago 3, Ill.

Medical TV Shows on Film. Describes four films available for use of medical societies on local TV stations and how to get them. Free from Department of Public Relations, American Medical Association, 535 N. Dearborn St., Chicago 10.

Schools of Nursing in Ohio—1953. Lists schools accredited by National League for Nursing, information on courses, costs, etc. Available free from Ohio League for Nursing, 137 E. State Street, Columbus, Ohio.

Mimeographed Health Materials. List of mimeographed reprints for health education of the public, as issued by the Bureau of Health Education, American Medical Association. Free from the Bureau, American Medical Association, 535 N. Dearborn St., Chicago 10.

School Health Services. A guide for health procedures in small or large school systems, prepared by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with cooperation of various contributors and consultants. Edited by Dr. Charles C. Wilson, Yale professor of education and public health. Available for $5 from American Medical Association, 535 N. Dearborn St., Chicago 10, or on loan from Ohio State Medical Association, 79 E. State St., Columbus 15.

Medical Exhibits for Medical Societies and Scientific Organizations. A 24-page catalog giving descriptions and pictures of medical exhibits available on loan from the A. M. A. Free from Director, Scientific Exhibit, American Medical Association, 535 N. Dearborn St., Chicago 10.

You and Your Public . . .

How To Check Local Public Relations Program; Paging System for Doctors Being Used; Talking It Over with Local Newspaper Editor

CHAIRMEN of county medical society public relations committees for 1954 are receiving from the Ohio State Medical Association a public relations checklist, and a packet of about two dozen booklets dealing with various phases of their work.

Using the checklist, the chairman and his committee can rate their society's public relations activities and attitude, and determine to an extent, the phases which need strengthening.

Supplementing the checklist, the booklets provide reference information about such projects as mediation committees, the handling of emergency accidents and illnesses of the community's residents; health council organization, and public relations conferences.

Other items covered are newspaper and radio relations, motion pictures available for television, medical education, cost of medical care and catalogues of health education literature, motion pictures, and exhibits available from the American Medical Association.

* * *

For several years the Montgomery County (Ohio) Medical Society has numbered all membership cards. The number appearing on his card is used by the doctor for paging purposes when he attends large gatherings in public places. This eliminates the necessity for calling him by name.

* * *

The following suggestion regarding press relations appeared in a recent issue of the *Newsletter* of the Medical Society of the State of New York:

"Letters to the editor of local newspapers voicing complaints against M. D.'s always present a difficult public relations problem for medical public relations men. A simple but effective means of meeting the issue has been tried out by one progressive county medical society in up-state New York. Here's how public relations men can adapt the plan for local use:

"1. Sit down with the editor *before* a 'letter-to-the-editor' problem arises. Make it clear that the county medical society wishes to cooperate with the editor and stands ready to investigate written complaints *before* they are published;

"2. Ask that a reporter be assigned to contact the society's public relations chairman as soon as any written complaints are received.

"3. Volunteer to have the public relations chairman accompany the reporter on a visit to the complaining letter writer;

"4. Assure the reporter that he should feel free to publish any legitimate complaint, if after making an impartial investigation, *facts* not rumors warrant a story.

"Reports indicate that as a result of this 'joint investigation' letters to the editor have not appeared in the pages of the local cooperating newspaper. While in a few instances the interviews revealed some justifiable minor complaints, the majority of cases investigated were found to be without foundation. The end result has been that the liaison reporter pays little or no attention to complaints of the 'letter-to-the-editor' type."

* * *

Directly and indirectly keeping up with progress in medical practice is good public relations. Your patients may voice an occasional good natured gripe when you're out of your office for a day or so, but in the long run they're a bit proud of their Doctor when they know he's "catchin' up on the latest."

In these busy times the average practicing physician still manages to devote the equivalent of 83.3 eight-hour days a year to keeping abreast of current developments in the field of medicine. This striking figure is brought out in a preliminary report by the A. M. A.'s Council on Medical Education and Hospitals on its recent survey of postgraduate medical education.

Survey findings are based on data compiled on personal visits to more than 220 institutions engaged in postgraduate medical education as well as 5,000 questionnaires received from a random sample of 17,000 practicing physicians throughout the country.

Over 41,000 practicing physicians took some form of postgraduate medical course last year.

Ways in which the doctor keeps up-to-date on medical matters are divided into five categories: (1) Medical reading; (2) professional contacts with colleagues, consultants, etc.; (3) hospital staff meetings; (4) attendance and participation in medical society and specialty group meetings at the local, state and national level; and (5) postgraduate courses conducted by some 26 different types of organizations — medical schools, health departments, medical societies, hospitals, etc.

About one-third of the time spent in continuing education is devoted to medical reading, another one-third to professional contacts and the remaining one-third divided among the other three forms.

NOT ARTHRITIS BUT ARTHRALGIA...

If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.[1] It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.[2] In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

"Premarin" is an excellent preparation for the replacement of body estrogen. In "Premarin" all components of the complete equine estrogen-complex are meticulously preserved in their natural form. "Premarin" produces not only prompt symptomatic relief but a distinctive "sense of well-being" which is most gratifying to the patient.

1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

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5410

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Four federal organizations—three Congressional committees and the Federal Trade Commission—currently are looking into various phases of health insurance. The four investigations are:

1. The well-publicized activity of the House Interstate and Foreign Commerce Committee, whose chairman, Charles Wolverton (R., N. J.), is anxious to have legislation passed to "reinsure" voluntary health plans.
2. Rep. Samuel K. McConnell, Jr., (R., Pa.), chairman of the House Education and Labor Committee, has received authorization and an appropriation to investigate the management of health and welfare funds set up as part of labor-management agreements.
3. The Senate Judiciary Committee, under chairmanship of Senator William Langer (R., N. D.), is investigating what it considers to be deceptive advertising practices of some mail-order health insurance companies. Before it ends its hearings the committee will get information from other health insurance companies and from insurance commissioners and will look into health insurance business practices.
4. The Federal Trade Commission for some time has been conducting a separate investigation, attempting to determine principally whether advertising and other representations of health insurance firms conform to actual policies.

* * *

The nurse shortage in the U. S. is acute and remedial action is urgently needed, Rep. Frances Bolton (R., Ohio) has informed Congress. Her findings were reported to the House as a result of a poll sent to 10,000 nurses, physicians, hospital administrators, state and federal officials and other interested laymen. Mrs. Bolton reported she had received returns from 38.5 per cent of those sent questionnaires.

Mrs. Bolton introduced a bill early in the last session for a federal program of grants for graduate nurse training and practical nurse training. The American Medical Association, in testimony to the House Commerce Committee, reiterated support of one-time construction or renovation grants to nursing schools on a matching basis and grants to states for advanced nursing scholarships.

Mrs. Bolton listed these findings, among others, in her report to the House: (1) Nurse shortage is most critical in general and private duty nursing, followed by teaching, supervision and administration categories, (2) low pay and long and irregular hours are major factors in the shortage, (3) more funds to nursing schools should remedy the shortage, and (4) a program of state-administered, federal-state matching funds is the preferred approach to the problem.

* * *

The Veterans Administration report for fiscal 1953, shows that the average daily patient load of administration patients in V. A. and non-V. A. hospitals remained about the same as the preceding year: 104,482. Admissions were 468,349, slightly less than the previous year. About 23,000 eligible veterans were awaiting admission, a thousand more than last year. Of these, only three were service-connected cases. They had been offered admission, but awaited admission to hospitals of their choice.

* * *

Ruling by Internal Revenue Service holds that if members of a hospital staff pool fees received from patients for subsequent distribution among themselves, they comprise a partnership and the group must file a partnership tax return (Form 1065).

* * *

Rep. A. W. Miller, (R., Neb.), a physician member of the House of Representatives, has been commended by the House Interstate and Foreign Commerce Committee for his work in bringing together divergent interests on a bill for more careful control of pesticide chemicals used in agricultural products. One of the main provisions of the bill is that a tolerance be established before a pesticide can be put on the market.

* * *

The overall narcotic addition situation in this country is said to be improving despite an eight-fold increase in seizures of raw opium last year. Deputy Customs Commissioner Chester A. Emerick says that the increase in seizures was caused by a bumper opium crop in parts of Mexico.

* * *

Another recent tax ruling: One may not deduct, under heading of medical expenses, sums expended for building a swimming pool or installing an elevator on taxpayer's property, even though these features were recommended by a physician for the purpose of conserving or protecting health.

Do You Know?...

Dr. Albert B. Sabin, Children's Hospital Research Foundation, Cincinnati, is scheduled to discuss "Active Immunization with Live Avirulent Viruses," during the Third International Poliomyelitis Conference, in Rome, Italy, September 6-10.

* * *

Dr. Joseph C. Placak was honored at a recent meeting of the Antituberculosis League of Cleveland and Cuyahoga County for his 50 years of work in the tuberculosis field. Herbert E. Zdara, president of the League, presented Dr. Placak with a portrait of himself, a gift of Ralph Wertheimer, painted by Basil Kalashnikoff, Cleveland artist.

* * *

Dr. Milton Rosenbaum, professor of psychiatry at the University of Cincinnati College of Medicine, on March 3, gave the first E. Van Norman Emory Memorial lectures sponsored by the Mental Health Association of St. Louis, Mo. He discussed "Psychosomatic Factors in Illness with Special Emphasis on the Role of the Doctor" and "The Role of the Father in the Family."

* * *

The University of Toledo has conferred upon Dr. Edward J. McCormick, President of the American Medical Association, the honorary degree of Doctor of Civil Law.

* * *

Dr. William H. Evans, Youngstown, will be one of the speakers at the annual meeting of the American College of Allergy in Miami Beach, Florida, April 5-10. His subject will be "Local Use of a Suspension of Cortogen Acetate with Chlor-Trimeton Maleate in the Treatment of Allergic Rhinitis of Pollen Origin."

* * *

Dr. Blanton E. Russell, manager of the V. A. hospital at Beckley, West Virginia, has been named to manage the new 496-bed general medical and surgical hospital at Cincinnati, construction of which is expected to be completed in March, 1954. It is tentatively scheduled for opening in June, 1954.

* * *

Members of Branch 11, American Medical Women's Association, held a joint dinner meeting with the Legal Women's Club in Cincinnati on January 26. The speaker was Dr. Frank Mayfield, Cincinnati, whose subject was "The Legal and Medical Aspects of Narcotics."

* * *

The 1954 Eastern States Health Education Conference of the New York Academy of Medicine will be held at the New York Academy of Medicine, 2 East 103 Street, New York City, on Thursday and Friday, April 29 and 30.

Nelsonville Selected as Site for State Tuberculosis Hospital

Nelsonville has been selected as the site of the proposed southeastern Ohio tuberculosis hospital, Dr. John D. Porterfield, director of the Ohio Department of Health, announced.

This selection was in accordance with the recommendation of the Department's Advisory Committee on Tuberculosis Care which met recently and made its report.

In announcing his decision, Dr. Porterfield pointed out that the principal factors influencing the selection were geographic location in relation to the population of the entire area to be served and the real and potential tuberculosis case load in this area.

While a number of other communities were generous in their promise to provide land and public utilities, Dr. Porterfield said, Nelsonville had an additional advantage in having already available a municipal fund which the city council had indicated was available for the provision of such water, sewage, power line and road provisions as would be necessary to the edge of the selected site.

Exact size and cost of facilities have not been determined, although it is understood that capacity will be in the vicinity of 70 beds.

Technical advisers and members of the Advisory Committee outlined the following considerations as to the type of facility that would be built:

That the architectural design be flexible and calculated to meet changing needs;

That adequate case finding facilities be provided;

That there be resources for community follow-up of discharged and unhospitalized cases, including social service;

That there be space for out-patient clinics;

That rehabilitation programs be established to retrain and return tuberculosis patients to society able to earn their own living.

That the hospital be a focal point to health education and that space for public health activities be provided.

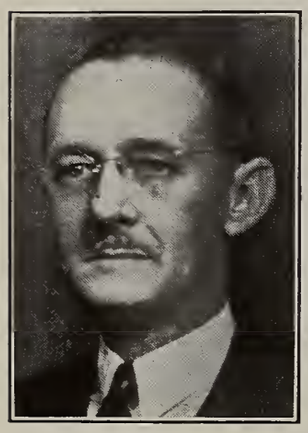
Akron—Dr. R. H. Wilson, medical director of the B. F. Goodrich Company, spoke before the Franklin Club of Akron on the subject, "Industrial Medicine."

Carbon Hill—The Community Club of Carbon Hill conducted a surprise birthday party for Dr. J. L. Webb, of Nelsonville, a native of the local community.

Chillicothe—Dr. John W. Wilce, professor of clinical and preventive medicine at Ohio State University, spoke on the subject, "You and Your Heart, with Sports Angles," at a meeting of the Chillicothe Kiwanis Club.

In Memoriam . . .

Harold Clay Messenger, M. D., Xenia; Medico-Chirurgical College of Philadelphia, 1914; aged 63; died February 23; member of the Ohio State Medical Association and the American Medical Association; member of The Council of the Ohio State Medical Association representing the Second District from 1943 to 1949; past-president of the Second Councilor District; member of the Ohio Academy of General Practice; delegate of the Greene County Medical Society to the State Association for more than 14 terms; president of the Greene County Medical Society in 1927 and 1930 and vice-president for two terms; also a former secretary-treasurer of the Society; active as chairman and member of numerous local Society committees.



H. C. MESSENGER, M. D.

After completing an internship at Miami Valley Hospital in Dayton, Dr. Messenger went into practice in Xenia with his father, the late Dr. Asa C. Messenger, in 1915.

During his more than 38 years of service as a practicing physician in Xenia, Dr. Messenger was outstanding in medical organization work and in service to his community. In addition to his years of service to the profession on the state level, he was tireless in his work with the local Medical Society. He served as chairman for several terms on the Legislative, Public Relations, Industrial Health and Military Advisory Committees. He also served on the Medical Defense, Membership and School Health Committees and on the local Board of Censors.

Dr. Messenger was a director of the Citizens First National Bank of Xenia and served as vice-president of the board for many years. During World War I, Dr. Messenger served with the Army Medical Corps and later became a member of the American Legion, serving at one time as post commander. During World War II, he was chairman of the Xenia City-Township Selective Service Board.

He was a 32nd Degree Mason, an Elder in the Presbyterian Church and a member of the Kiwanis Club. Surviving are his widow; two sons, one of whom is Dr. H. Clay Messenger, Jr., of Dayton; his mother and two sisters.

Roy F. Drury, M. D., Akron; Ohio State University College of Medicine, 1914; aged 65; died February 16; member of the Ohio State Medical Association. Dr. Drury served virtually all of his professional career in Akron, with the execption of time served as a Captain in the Medical Corps during World War II. Affiliations included memberships in the Masonic Lodge and the Executive Club. Surviving are his widow, a brother and a sister.

Frank J. Erdhaus, M. D., formerly of Cincinnati; Cincinnati College of Medicine and Surgery, 1898; aged 83; died February 14. A practicing physician in Cincinnati for many years, Dr. Erdhaus had retired some time ago and was making his home in Glen Ellyn, Ill.

Ida E. Fleming, M. D., Cleveland; Ohio State University College of Medicine, 1921; aged 56; died February 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Fleming was associated with the Cleveland Division of Health for 32 years, most of which time she was physician in charge of health work in parochial schools. She was a member of the Women's Medical Society of Cleveland.

Roger W. Gridley, M. D., Orlando, Fla.; Ohio State University College of Medicine, 1945; aged 40; died February 1 in a plane crash. A former resident of the Springfield area, Dr. Gridley served during the War with the Army Medical Corps. He had been practicing in Orlando for six years. Survivors include three children, two brothers and four sisters.

William Lewis Hobart, M. D., Lakewood; Hahnemann Medical College of Philadelphia, 1919; aged 59; died February 28; member of the Ohio State Medical Association and the American Medical Association; member of the American Academy of General Practice. Upon completion of his internship, Dr. Hobart moved to Lakewood and had been practicing there since. Affiliations included memberships in the Methodist Church, the Westwood Country Club, Clifton and Union Clubs, the Northern Ohio Opera Association, Friends of Cleveland Orchestra, Cleveland Health Museum, and Phi Epsilon Rho. Surviving are his widow and two brothers.

William Dallas Hoyer, M. D., Sandusky; Ohio Medical University, Columbus, 1900; aged 78; died February 23; former member of the Ohio State Medical Association, last in 1931. Dr. Hoyer practiced in Columbus until 1904, when he moved to Sandusky. His practice there was continuous except for a period from 1915 to 1923 when he was in Cleveland and Columbus as head of Women's Hospitals. A recipient of the Ohio State Medical Association's 50-Year Pin, he was a 32nd degree Mason. Survivors include his widow, a son, two sisters and a brother.

Matthew C. Hunter, M. D., New Orleans, La.; Ohio State University College of Medicine, 1916;

aged 64; died February 11; former member of the Ohio State Medical Association, last in 1930. A former practicing physician in Greenville, Dr. Hunter had been with the Veterans Administration for a number of years before his recent retirement. Survivors include his widow and three children.

Irving J. Johnson, M. D., Marietta; Baltimore University School of Medicine, 1897; aged 80; died February 5; member of the Ohio State Medical Association. A recipient of the Ohio State Medical Association's 50-Year Pin, Dr. Johnson had practiced a total of 57 years, the first 16 years in Constitution and the remainder in Marietta. He served with the Medical Corps during the Spanish-American War and was a member of the Spanish-American War Veterans. Other affiliations included memberships in the Odd Fellows Lodge, the Elks Lodge, Modern Woodmen of America and the Presbyterian Church. He is survived by his widow and a daughter, Mrs. Fred I. Rose, of Columbus, wife of Dr. Rose.

William McKinley Johnston, M. D., Akron; Ohio State University College of Medicine, 1925; aged 55; died February 8 in a traffic accident; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Johnston took up the study of medicine after serving with the Navy in World War I. Upon completion of his education, he moved to Akron where he had practiced since with the exception of service during World War II. As a Naval medical officer, he attained the rank of Commander. Surviving are his widow, his mother and two brothers.

William Charles McCord, M. D., Poland; University of Pittsburgh School of Medicine, 1905; aged 75; died February 7; former member of the Ohio State Medical Association, last in 1931. Dr. McCord practiced in Columbiana before moving to Poland 21 years ago. Memberships included the Odd Fellows, the Knights of Pythias and the the Masonic Lodge. Surviving are his widow, two daughters, three sisters and a brother.

Louis Mark, M. D., Columbus; Marquette University School of Medicine, 1915; aged 61; died February 25; member of the Ohio State Medical Association and the American Medical Association; fellow and past-president of the American College of Chest Physicians and fellow the American College of Physicians. After an internship at Cincinnati General Hospital, Dr. Mark practiced for a while in Washburn, Wis., and during World War I held a military appointment with the Ohio State Sanitarium at Mt. Vernon. He purchased the Rocky Glen Sanatorium at McConnelsville in 1919 and had managed it since. About that same time he moved his private practice to Columbus. He had been chief of the Department of Chest Diseases at White Cross Hospital since 1927. Dr. Mark traveled extensively and had given medical lectures by invitation in England, France, Italy, Portugal, Israel and several South American countries. Only recently he headed a group of 55 medical authorities through South America as representatives of the American College of Chest Physicians and Surgeons. He was past-president and a life master of the American Contract Bridge League and a member of its board; also president-emeritus of the Central Ohio Bridge Association. A member of the Winding Hollow Country Club, he held the golf championship of the club for 17 years. Other affiliations included membership in the Bryden Road Temple, Temple Tifereth Israel and Ahavas Sholom, the Masonic Lodge, the Athletic Club, Excelsior Club and the Chamber of Commerce. Surviving are his widow; two daughters; a son, Dr. Lloyd Mark; three sisters and three brothers.

Mervin H. Mitchell, M. D., Albany; Ohio State University College of Medicine, 1932; aged 58; died January 29; member of the Ohio State Medical Association; member of the American Medical Association; president of the Athens County Medical Society in 1950 and a delegate of the Society to the Ohio State Medical Association for three terms. Dr. Mitchell was a practicing physician in Albany for the past 12 years. Prior to moving there, he practiced in Rio Grande (Ohio) and in West Virginia. Surviving are his widow, a daughter, a son and two brothers.

Harold Vieman Postle, M. D., Columbus; Ohio State University College of Medicine, 1916; aged 64; died February 28; former member of the Ohio State Medical Association, last in 1940. In practice in Columbus for most of his professional career, Dr. Postle was physician for the Pennsylvania Railroad for 30 of those years. He was a veteran of World War I. Surviving are his widow and a daughter.

Wightman Tillotson Reid, M. D., Cincinnati; Vanderbilt University School of Medicine, 1905; aged 71; died February 10. Born in China, the son of missionary parents, Dr. Reid was superintendent of a Korean hospital for many years. Surviving are two sons and two daughters.

John Lewis Roman, M. D., Batesville; Ohio Medical University, Columbus, 1906; aged 74; died January 28; former member of the Ohio State Medical Association. Dr. Roman had practiced medicine at Calais, Mt. Perry, Perrytown, Sarahsville, and Otsego before establishing his office at Batesville in 1921. He was a member of the Methodist Church, and a past-president of the Noble County Board of Health. Survivors

include his widow, a son, two daughters, two sisters and a brother.

Thomas Dominicus Santurello, M. D., Columbus; Ohio State University College of Medicine, 1924; aged 56; died February 13; member of the Ohio State Medical Association; member of the American Academy of General Practice. Dr. Santurello served all of his professional career in Columbus, with the exception of service time with the Army Medical Corps during World War II. He was a member of the American Legion, and the Dante Club. Dr. Santurello served for several years on the Ohio Board of Cosmetology where he was in charge of sanitation and hygiene phases of the board's work. Survivors include his widow, a son and two daughters.

Edward Paul Schneider, M. D., Canton; St. Louis University School of Medicine, 1942; aged 36; died February 10; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Schneider returned to his native Canton upon completion of a residency at Mayo Clinic, and had been practicing there since. Affiliations included memberships in the Catholic Church and the Catholic Physicians Guild. Surviving are his widow, a son, two daughters, his mother, a sister and a brother.

George Washington Smith, M. D., Canton; Eclectic Medical College, Cincinnati, 1904; aged 79; died February 4; member of the Ohio State Medical Association and the American Medical Association. Dr. Smith began his practice in West Virginia and moved to Canton in 1910 where he continued to practice until retirement within the past year. He was a member of the Reformed Church. Survivors include his widow, three sisters and three brothers.

Paul Whiting Tappan, M. D., Dayton; Miami Medical College, Cincinnati, 1902; aged 76; died February 21; former member of the Ohio State Medical Association. Dr. Tappan served virtually all of his professional career in Dayton and continued to practice until his retirement a few years ago. He was a member of the Masonic Lodge, the Dayton Club and the Miami Valley Golf Club. Surviving are his widow, a daughter, three sisters and two brothers.

Ernest Wood, M. D., Galena; Rush Medical College, University of Chicago, 1902; aged 78; died February 28. Dr. Wood's medical career included positions as plant physician in Kitchener, Ont., and Calumet, Mich., and the staff of the Highland Park Hospital, Ill. He served for 21 years on the staff of the Gallipolis State Institute. Surviving are his widow, a daughter, a son and a brother.

Military Estimates It Will Need 4,500 Doctors For July 1 Fiscal Year

During the next fiscal year, starting next July 1, the Defense Department expects that all hospital interns and residents obligated for military service will have to be called to active duty. However, according to Assistant Secretary Berry, the demand may not be as heavy during the first half of the period, due to a backlog of 1953 medical school graduates and a small number left over from Priority I. For the men facing almost inevitable calls, Dr. Berry urges hospitals to make short-term arrangements so they "will have a means of livelihood and also the opportunity to continue their education, as well as to contribute to the needs of the hospitals," while awaiting orders the last six months of this year and the first six months of next.

National Advisory Committee to Selective Service advises that after July 1, 1955, all physicians with military obligations should obtain commissions during their internships. This will remove them from the jurisdiction of their draft boards, and allow Defense Department to request delay in call for men the Department recommends for additional training.

This information is contained in a statement from Dr. Berry, in charge of medical and health matters for the Department of Defense. Dr. Berry also presented the results of a poll of medical school deans, who were requested to ask fourth year students the following questions: (1) If given free choice, which service would you prefer? (2) Do you prefer to serve your time immediately following internship? (3) Or following internship and one year of hospital training? (4) Or following full residency training?

The results showed 27 per cent of the students preferred the Army, 37 per cent the Navy and 36 per cent the Air Force. 39 per cent preferred service immediately following internship, 15 per cent preferred it after two years of hospital training and 46 per cent preferred military duty after full residency training.

The Defense Department estimates it will need about 4,500 physicians for the fiscal year, July 1, 1954, to June 30, 1955.

Cleveland—Dr. E. D. Saunders, for many years chief of obstetrics at Fairview Park Hospital, was honored at a reception at the hospital upon his retirement from the post and was presented a scroll in appreciation of his more than 40 years service to the hospital. He will continue in private practice.

Ironton—New chief of staff at the General Hospital is Dr. John A. Dole. Dr. Harry Nenni was named vice-chief and Dr. G. N. Spears secretary-treasurer.



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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

CLINTON

A four-county meeting was held in Wilmington on February 3 when the Clinton County Medical Society was host to members of Medical Societies from Highland, Greene and Fayette Counties.

A team of physicians from Cincinnati conducted the program. They and their subjects are as follows: Dr. Ralph Carothers, "The Fall on the Outstretched Hand"; Dr. Nicholas Giannestras, "Principles of Tendon Surgery"; Dr. William Thornell, "Treatment of Nasal Fracture," and Dr. Frank Mayfield, "Causalgia—Its Prevention and Treatment."

HAMILTON

The Academy of Medicine of Cincinnati in early February moved to its new headquarters office location at 152 East Fourth Street.

Recent programs of the Academy include the following features and speakers:

February 2—"Benign Diseases of the Pancreas," Dr. John H. Mulholland, professor of surgery, New York University College of Medicine.

February 16—Symposium on "The Surgical Management of Massive Hemorrhage from Gastrointestinal Tract," with the following participants: Dr. Stanley O. Hoerr, associate professor of surgery, Frank E. Bunts Institute, Cleveland; Dr. John D. Stewart, professor of surgery, University of Buffalo Medical School; Dr. Leon Schieff, associate professor of medicine, University of Cincinnati College of Medicine; Dr. Paul I. Hoxworth, associate professor of surgery, University of Cincinnati College of Medicine, moderator.

March 2—"Drugs in the Treatment of Heart Disease," Dr. Charles K. Friedberg, professor of medicine, Columbia University College of Physicians and Surgeons.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

DARKE

"Indications for Open Reduction of Fractures" was the topic of a talk by Dr. R. C. Rounds, Dayton, at the February 16 meeting of the Darke County Medical Society in Greenville.

MONTGOMERY

For the third consecutive month Montgomery County Medical Society physicians exceeded the 50 per cent of membership attendance mark at a regular monthly meeting. Speaker for the March 5 meeting which was attended by 241 doctors was William Alan Richardson, Editor Medical Economics, Inc. Mr. Richardson took as his topic, "Liquidating Your Poor Relations." The February meeting of the M. C. M. S. hit a high with an attendance of 291 while the January meeting was attended by 250 physicians.

Ohio State Medical Association 50-Year Awards were presented to eight physicians at the March 5 meeting by Dr. George Woodhouse, Councilor of the Second District. The eight physicians are: S. M. Beck, M. D.; W. G. Claggett, M. D.; R. K. Evans, M. D.; H. C. Mundhenk, M. D.; E. H. Morris, M. D.; H. H. Webster, M. D.; P. A. Kemper, M. D.; A. B. Martin, M. D.

The Medical Society announced also that it was organizing the second in a series of Health Forums in connection with the *Dayton Daily News*. The Forums this year will begin on April 21, and will continue for four weeks. The 1953 Forums were attended by 6,000 persons on four consecutive Wednesday nights.

Announced also, was the new series of Indoctrination Committee meetings with all new members of the County Society. Seven sessions are planned during March, April, and May. The first two sessions will be devoted to the principles of Medical Ethics. Others will include a

for emotionally disturbed children . . .

THE ANN ARBOR SCHOOL

. . . is a private school for children from six to fourteen, of average or superior intelligence, with emotional or behavior problems.

. . . providing intensive individual psychotherapy in a residential setting.

A. H. KAMBLY, M. D.
Director

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A combined full time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the Ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical medicine; continuous instruction in cystoendoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as prostatic resection.

ANESTHESIOLOGY

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session on religion and medicine, medicine and the community, medicine and law, doctor and hospital relationships, and finally, a panel on fees.

PREBLE

Eaton physicians have set up a system of providing emergency service for the community on Thursdays when offices normally are closed. Announcement is made in advance of the physician who will be available for emergency calls only.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

"The Problems of Early Cancer," was the topic discussed by Dr. Edward A. Gall, director of the Department of Pathology, University of Cincinnati College of Medicine, at the February 16 meeting of the Lima and Allen County Academy of Medicine.

MARION

Two physicians were presented 50-Year Pins of the Ohio State Medical Association at a recent meeting of the Marion County Academy of Medicine. They are Dr. E. H. Morgan and Dr. E. L. Brady. Dr. James R. Jarvis, Van Wert, Councilor of the Third District, made the presentations.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The Inter-Hospital Postgraduate Lecture Series was held at the headquarters building of the Academy of Medicine of Toledo on February 18-19. The program was presented by the Medical Advancement Trust of the Maumee Valley Hospital. Speaker was Dr. James V. Warren, professor of medicine, Duke University School of Medicine, Durham, N. C. The theme of the series of talks was "Clinical Physiology of the Cardio-Respiratory-Renal System."

PUTNAM

The Putnam County Medical Society honored three physicians for a half-century of service in the medical profession at its February 2 meeting.

Dr. J. A. Harold, Ottawa, was presented the 50-Year Pin and Certificate of the Ohio State Medical Association by Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District. Dr. Harold moved to Putnam County in 1908 and located at Glandorf, later moving to Ottawa.

Awards were presented in absentia to two other physicians, Dr. W. C. Miller, of Belmore, former county coroner, and Dr. Elisha Blackburn, who practiced for many years in Putnam County, but who is now residing in Worthington.

Principal speaker for the occasion was Dr. Orr who discussed medical and hospital problems.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

SUMMIT

Dr. Darrel Thomas Shaw, Cleveland, spoke on the subject, "The Newer Aspects of Plastic Surgery," during the March 2 meeting of the Summit County Medical Society on the University of Akron campus.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Speaker for the January 21 meeting of the Belmont County Medical Society was Dr. Edward S. Phillips, Wheeling, W. Va., who spoke on "Some Aspects of Plastic Surgery." The joint meeting with the Auxiliary was held at the Belmont Hills Country Club.

The Society and Martins Ferry Hospital medical staff held a joint meeting at the Hospital on February 18. The program consisted of a clinicopathological conference put on by the staff.

TUSCARAWAS

The annual spring party of the Tuscarawas County Medical Society and Auxiliary was held at Bonvechio's on March 10, when physicians' office assistants were guests.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The subject, "Alcoholism," was discussed by Dr. Herbert Chamberlain, McArthur, at the March 8 meeting of the Scioto County Medical Society in Portsmouth.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

ROSS

Members of the Ross County Academy of Medicine were guests of Dr. John Franklin and Dr. L. T. Franklin at the latter's home on February 4. Mr. Howard Carson and Dr. Robert Fleming, of the Holzer Clinic, Gallipolis, discussed "The Early Diagnosis and Treatment of Carcinoma of the Cervix."

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

An address on "Peripheral Vascular Disease" was given by Dr. S. A. Simeone, Cleveland, at the January 12 meeting of the Lorain County Medical Society in the Spring Valley Country Club, Elyria.

The regular meeting was held on February 9 at the Spring Valley Country Club, Elyria, with dinner. Following a business meeting, a me-

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1. Cowart, E. C., Jr.: Mississippi Doctor 29:278 (April) 1952.
2. Sayer, R. J., et al.: Am. J. M Sc. 221:256 (March) 1951.
3. Knight, V.: New York State J. Med. 50:2173 (Sept. 15) 1950.
4. Trafton, H. M., and Lind, H. E.: J. Urol. 69:315 (Feb.) 1953.

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morial address for the late Dr. Ralph W. Faus, was given by Dr. Sidney Stone.

The scientific program consisted of a talk by Dr. Donald M. Glover, Cleveland, on the subject, "Surgical Emergencies in Infancy."

Dr. S. A. Simeone, Cleveland, addressed the Lorain County Medical Society on March 9. The meeting was held at the Spring Valley Country Club, Elyria.

RICHLAND

Approximately 55 members of the Richland County Medical Society met at the Mansfield General Hospital on February 18. Dinner was served at the hospital and a business meeting followed.

The scientific program was presented by Dr. William N. Taylor, professor at the Ohio State University College of Medicine. His subject was "Urology."

Activities of Woman's Auxiliary . . .

By MRS. EDWARD L. VOKE, Chairman, Publicity Committee, 243 Hampshire Road, Akron 13, Ohio

President—Mrs. N. M. Reiff, 404 Rawlings Street, Washington Court House
President-Elect—Mrs. A. Paul Hancuff, 3551 Maxwell Road, Toledo 13
Vice-President—Mrs. O. W. Jepson, Bowen Road, Canal Winchester
Recording Secretary—Mrs. O. Reed Jones, Green Acres Estate, Cambridge
Corresponding Secretary—Mrs. James E. Rose, 729 Washington Avenue, Washington Court House
Treasurer—Mrs. Karl Ritter, 1420 Shawnee Road, Lima
Past-President—Mrs. Paul M. Woodward, 1500 Hollywood Avenue, Cincinnati 24

A. M. E. F.

Since last report, 12 additional County Auxiliaries have made contributions to the American Medical Education Foundation, reported Mrs. George W. Cooperrider, Columbus, chairman of the fund committee. They are: Lake, Franklin, Wood, Ottawa, Ashtabula, Stark, Champaign, Meigs, Pike, Auglaize, Medina, and Van Wert.

ALLEN

On December 15, 1953, a dinner-dance was enjoyed by 65 doctors and their wives at the Shawnee Country Club. The January meeting was an all day one held in the home of Mrs. Charles H. Leach. During the morning, slippers for patients in local hospitals were made. After luncheon, Mrs. Gietform Sundfor, president of the Y. W. C. A., discussed its program. Mrs. William Noble spoke on the Mothers' March on Polio drive. Mrs. J. W. Burke, Mrs. D. L. Becker, and Mrs. H. C. Kingsberry assisted the hostess.

ASHTABULA

A nominating committee and committee for a bake sale were appointed at the March meeting at the dinner meeting held in the Hotel Ashtabula. Those on the nominating committee were Mrs. John Rentschler, chairman, Mrs. Charles Suttles and Mrs. Frank Verone. Mrs. Carl Streicher, Mrs. Byron Johnson, Mrs. Rentschler, Mrs. Verone, and Mrs. J. J. O'Bell comprise the committee for the bake sale.

BUTLER

Dr. D. A. Balier, superintendent of Longview Hospital and Dr. Paul Balirenberg, head of the children's department at the same institution, were guest speakers at the February Auxiliary meeting.

Serving on the arrangements committee for the meeting at Verity Hall were Mesdames William Hall, chairman, Roos Hill, Charles Buchert, L. H. Skimming, and Thomas Wenzel.

The Butler Auxiliary was recently given the Woman's Home Companion's 1954 Honor Club Award for distinguished service to its community. The group was one of 250 women's clubs so honored.

Auxiliary members recently entertained their husbands at dinner at the Hamilton City Club. Dancing and card playing followed the dinner.

CHAMPAIGN

Discussion on Mental Health followed the February luncheon meeting of the Auxiliary in Millner's Colonial Room. President Mrs. F. E. Lowry appointed the delegate and alternate to the State Convention in April in Columbus. Mrs. I. Miller was appointed as delegate and Mrs. John Polsley as alternate.

It was guest day at the March meeting in Mercy Memorial Hospital. The speaker, Mrs. William T. Gillie of Urbana, president of the Champaign County Mental Health Association, talked on "Fundamentals of Good Mental Health."

CLARK

Husbands of members attended the December dinner meeting in the Shawnee Hotel. Mrs. Martin J. Cook was in charge of the program, assisted by Mrs. John Horley, Mrs. Wesley Knaup, and Mrs. George Parker. Mrs. Starling C. Yinger was hospitality chairman for the January business meeting held in the Nurses Home at Springfield City Hospital. Mrs. E. W. Schilke, scholarship fund chairman, reported on progress of the annual gardenia sale, the proceeds of which go to the nurses' fund.

The Auxiliary held a bridge party in February

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1. Rev. Gastroenterology 20:744 (Oct.) 1953; abstract in J. A. M. A., 153:1580 (Dec. 26) 1953.

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at the home of Mrs. C. W. Hullinger. Mrs. George P. Fitzgerald, Jr., conducted the business meeting. The hospitality committee included Mrs. R. H. Mabry, chairman, Mrs. Francis Link, Mrs. Paul W. Schaner, Jr., and Mrs. John E. Burnett, Jr. It was announced that Mrs. E. W. Schilke and Mrs. C. E. Fralick would serve as co-chairman for the gardenia sale in March, the proceeds of which will be used for nurses' scholarships.

COSHOCTON

The Auxiliary met at the home of Mrs. G. M. Ebersole for the February meeting. Mrs. Floyd W. Craig, president, and Mrs. G. A. Foster, vice-president, were elected delegates to the state meeting to be held April 13, 14 and 15. Mrs. W. R. Agricola gave a review of the book, *Forty Old*, by Mary Bard.

DELAWARE

A program on "Today's Health" was presented by Mrs. M. W. Livingston at the meeting held at the home of Mrs. Tennyson Williams. Mrs. E. C. Jenkins, the president of the Auxiliary, was appointed Chairman of the 1954 Heart Fund Drive by Mrs. R. W. Kissane. The local drive was sponsored by the group.

Johnny Jones of the *Columbus Dispatch* showed slides and discussed a trip he had taken with four paper carriers to South America, at a dinner meeting of the Auxiliary in February. The members' husbands were their guests and Mrs. James G. Parker was in charge of arrangements.

The Heart Fund Drive was spark-plugged by the Auxiliary. Mrs. E. C. Jenkins was the chairman. The following members were captains on the committee: Mesdames E. V. Arnold, A. R. Callander, Wray Davies, D. L. Gantt, E. C. Jenkins, M. W. Livingston, of Sunbury, G. J. Parker, J. G. Parker, D. L. Smith, F. M. Stratton, C. B. Theiss, and Tennyson Williams.

ERIE

At the January meeting of the Auxiliary, Richard Shimer, local F. B. I. agent was the speaker. He explained the responsibilities and activities of the F. B. I. and told about their laboratory and training school for the agents and the local police. Mrs. C. E. Swanbeck and Mrs. A. G. Groscost were the hostesses for the day.

A program featuring the Mello-Chords of Sandusky High School, a brass quartet, and piano selections by Paula Squire, was enjoyed by the Auxiliary which met in the Business Women's Club for its February meeting. Hostesses were Mrs. J. L. Carroll, Mrs. H. L. Williams, Mrs. J. P. Ohlmacher and Mrs. D. B. Cuthbertson. Mrs. W. F. Burger had charge of the musical program.

In spite of a raging March blizzard, the Auxiliary enjoyed a style show given at the Business Women's Club. Robert Shiff was the commentator and the models were Carolyn Henderson, Sue Parry, Donna Richey, Mrs. Paul Squire, Mrs. William Burger, and Mrs. E. J. Meckstroth. Hostesses were Mrs. Squire, Mrs. A. R. Grierson, Mrs. F. E. Reed, and Mrs. Meckstroth.

FAIRFIELD

Mrs. Fred Spangler conducted the January meeting held in the Pine Room of the Hotel Lancaster. Plans were discussed for the annual party for the County Home. Mrs. C. R. Reed, Project Chairman, was in charge. Mrs. Wm. Jasper, Chairman of the Prospective Student Nurses Tea, announced that plans for it were well under way. Hostesses for the meeting were Mrs. Wm. Jasper, Mrs. George Jones, Mrs. M. E. Nichols, and Mrs. L. E. Stenger. Mrs. Stanley Sneeringer and Mrs. A. B. Van Gundy were appointed delegates to the State meeting in Columbus in April.

Mrs. Fred Jones, Civilization Defense Chairman, addressed the members of the Auxiliary at the February meeting held in the Hotel Lancaster. Redecorating the living rooms of the Nurses' Home was adopted as a new project by the group. It was voted to contribute to the Y. M. C. A. and Y. W. C. A. building drive. Hostesses for the meetings were Mesdames W. D. Misbaum, C. R. Reed, V. A. Simiele, and Fred Spangler. Mrs. Reed was chairman of the "Sweetheart Party," a Valentine party for "Oldsters," at the Fairfield Country Home.

FRANKLIN

A dramatic monologue, "Anne of the Thousand Days," by Maxwell Anderson, was presented by Rose Mary Adams at the January meeting held in the Columbus Gallery of Fine Arts. She was introduced by Mrs. Richard Zollinger who planned the program. Mrs. William Blesch, chairman of the tea, was assisted by members of the social, ways and means, and year-book committees.

Dr. Robert W. Foy, rector of Trinity Episcopal Church, spoke at the Auxiliary's February meeting held in the Columbus Gallery of Fine Arts. He was introduced by Mrs. H. William Clatworthy, Jr. Mrs. Walter Lawenstein served tea assisted by the social, project, and finance committee.

GUERNSEY

At the January meeting in the home of Mrs. James L. Toland, plans were completed for the annual Nurse Recruitment party for high school girls. Mrs. Howard F. Van Noate had charge of arrangements. Mrs. Milton N. Thompson, the guest speaker, described her recent trip to England and Ireland. Mrs. W. L. Denny and Mrs. F. Lordon Lawyer were chosen to represent the group in April at the State Auxiliary Con-

vention in Columbus. The president, Mrs. Robert Ringer conducted the business meeting.

It was voted to send renewal subscriptions of *Today's Health* to the high schools in the county. Mrs. Reo M. Swan and Mrs. Lawyer were named co-chairmen of the magazine committee. The Auxiliary entertained 75 high school girls at the third annual Nurse Recruitment Party at Guernsey Memorial Hospital. Brief talks were given by Miss Althea Williams, Nursing Supervisor and Mrs. Fred J. Picknell, the Administrator of the Hospital. Mrs. Ringer, the president, and Mrs. Van Noate, the party chairman, presided at the refreshment table.

HAMILTON

The annual dinner-dance of the Woman's Auxiliary to the Hamilton County Medical Society was held Saturday, December 5, at the Maketewah Country Club. This is the one festivity of the year of the Auxiliary to which husbands of members are invited, and the one event which makes it most possible for the Auxiliary to carry out its two-fold purpose: "To cooperate with the Academy of Medicine of Cincinnati in promoting health education and to promote good fellowship among physicians' families."

The dance is given each year for the Auxiliary's educational and philanthropic fund. The proceeds from the dance, December, 1952, enabled the Auxiliary to present various gifts which were used by the recipients in the following manner: The College of Nursing and Health gave a full one-year scholarship; the Hillcrest School for Girls bought gifts for girls who would not have had any and supplied a Christmas tree for the School; a contribution was given to the Practical Nursing Training School; the American Educational Foundation designated its contribution to the University of Cincinnati Medical College. Each year the funds are divided in a similar manner.

There were 340 doctors and their wives attending this affair. It was the feeling of everyone that these affairs be continued in the future.

HARDIN

The Mistletoe Ball held during the Christmas season netted the Auxiliary $1,300.00. The affair sponsored by the group to equally benefit the San Antonio and Hardin Memorial Hospitals.

Miss Ruth Lumey, city health commissioner, gave a talk describing her personal experiences and the work of the department for the past 20 years, at the February dinner meeting of the Auxiliary held at the San Antonio Hospital.

Mrs. W. D. DeWar, president, conducted the meeting at which time Mrs. H. R. Johanson was named chairman of the Nurse Recruitment Tea. Mrs. Floyd Elliott gave a report on current legislation.

HURON

"Today's Health" was the title of the program at the January meeting of the Huron County Auxiliary.

Mrs. T. H. Smith, President, conducted the business meeting following a dessert luncheon at the home of Mrs. W. A. Drury, Willard, Ohio.

KNOX

Dr. John Baube, guest speaker at the January meeting in the home of Mrs. D. C. Schmidt, spoke on Public Health in Mount Vernon—"As It Is and As It Should Be." Co-hostesses were Mrs. Richard Gomer and Mrs. Carroll Conard. Reports were made on the hospital sewing guilds.

LICKING

A guest dinner party for husbands was held at the Newark Country Club in December instead of the regular meeting. Mrs. Kenneth Wells, executive director for the Ohio Mental Health Association, was introduced as the guest speaker by Mrs. Kenneth Wells at the January meeting held in the Y. M. C. A.

Following the talk, Mrs. Carl Petersilge presided at the business meeting at which time Mrs. Ralph Pickett and Mrs. Paul Grove were appointed delegates to the State Auxiliary Convention held in Columbus in April. Mrs. J. Salzman reported on current legislation. Mrs. Wm. Wells presented a report on the nurse recruitment program. The nurse recruitment committee, consisting of Mrs. Wells, Chairman, Mrs. Petersilge, Mrs. Dale Roth, Mrs. Paul C. Grove, Mrs. J. R. Wells, Mrs. Norris Burleson, Mrs. Charles Sensabaugh, Mrs. Warren Koontz, Mrs. E. C. Lane, and Mrs. Raymond Ward, met January 28 at the home of Mrs. Paul Grove.

Mrs. J. R. Wells was in charge of the program presented in Newark High School to give students facts on entering nursing. Mrs. Petersilge gave a similar program in Granville, Mrs. Grove in St. Francis de Sales School, Mrs. Lane in Hebron High Schools and Mrs. Ward in Alexandria.

The Auxiliary met for its next dinner meeting in the Hotel Warden. Following the business session a make and bake sale was held with Mrs. Ralph Pickett as auctioneer.

The film "The Way to Nursing" was shown. Mrs. William Wells reported on the recruitment project of which she is chairman. The auxiliary scholarship offers $300 and a similar one is being offered by the County Medical Society. Mrs. Paul Grove told of preliminary work in organizing a Future Nurses' Club in Granville, and Mrs. Warren Koontz presented the publicity for nurse recruitment.

On recommendation of Mrs. A. S. Burton, the magazine *Today's Health* will be sent to Newark and St. Francis de Sales High Schools. Mrs.

Roland Jones was named to investigate and report on current needs of Newark Hospital. Plans were made for the auxiliary to act as the volunteer staff for the Bloodmobile in an early visit and Mrs. C. G. Faue will be in charge of arrangements.

Several meetings have been arranged and addressed by members of the Nurse Recruitment committee of the Auxiliary. They have been meeting with high school students, interested in nursing as a career, and giving vocational guidance to junior high school students. Another phase is the sponsoring of a new "Future Nurses' Club" in Granville.

The school nurse organized the meeting and Mrs. Paul Grove told of the possibility of the club and assisted with its organization. Mrs. J. R. Wells, Mrs. U. S. Araz and Mrs. Carl Petersilge attended as auxiliary representatives. The Future Nurse Club in Granville was the first to be organized in Licking County.

Included in the other activities was the screening of the film "Keepers of the Lamp" for Alexandria students with Mrs. Edgar Johnson representing the committee. Mrs. Paul Grove showed the same film at Wilson Junior High School.

Similar programs were presented in Newark High, Granville High, St. Francis de Sales High School and students at Hebron High School were given vocational guidance.

Mrs. Gail Walters, R. N., director of the nursing services at Newark Hospital, with members of her staff, joined the auxiliary in presenting several of the high school programs. The participants were dressed in the uniforms of their various nursing schools. Extra caps and student uniforms were also on display.

LOGAN

In January the Auxiliary enjoyed a luncheon meeting at the home of Mrs. George Freetage. Mrs. Warren F. Mills, the president, conducted the business session followed by a social hour.

The annual Christmas dinner was served at the home of Dr. and Mrs. Warren F. Mills of Bellefontaine. Mary Rutan Hospital administrator, and Mrs. Robert Koshner were guests. Guests were seated at small tables near the gaily decorated Christmas tree.

LORAIN

Amos Burrows, executive director of the Lorain Community Chest and secretary of the Community Welfare Council, was guest speaker at the luncheon meeting in Heilman's Restaurant in January. Mrs. Gerard Krupp, program chairman, introduced the speaker.

Mrs. Theodore Finegan conducted the business session when Mrs. G. R. Wiseman and Mrs. Theodore Berg were appointed delegates to the State Auxiliary convention in Columbus in April.

Mrs. Franz Gruen, social chairman, gave completed plans for an informal buffet supper dance at Spring Valley Country Club February 20. Mrs. Finegan announced Mrs. Wiseman has been appointed to the State Auxiliary's nominating committee.

LUCAS

The Go See Study Club toured the Toledo State Hospital in January. Mr. Joseph Duty, hospital superintendent, spoke. Mrs. Robert Curl is chairman of the study group.

Mrs. Myron G. Means and Mrs. A. Paul Hancuff, chairman of the first Mothers' March on Polio, presided at the tea which the Auxiliary sponsored in January in honor of the many volunteers responsible for collecting a record amount of $66,973.00.

Members of the Health Committee met at the home of Mrs. E. J. Singer, co-chairman. Reports were given by Mrs. Frank A. Rawling, representing the field of allergy; Mrs. J. E. Minns, heart; Mrs. Hazen Haumann, infantile paralysis; and Mrs. Singer and Mrs. Henry Hartman, mental hygiene.

Child Study Development Group met at the home of Mrs. R. P. Whitehead, Jr. Mrs. William A. Phillips is chairman of the group. Mrs. Wendall Schlichting led the discussion following the showing of a film.

The Live Issues of Today Study Group met at the home of Mrs. Wm. Newborn. Mrs. David Katchka led the discussion and Mrs. Wendall Green was chairman for the day.

The Live Issuse evening group meet with Mrs. Richard Schneider. Mrs. Ned B. Hein and Mrs. Jack Millis led a discussion of "Shall We Recognize Red China?" Dr. Bienvenido Tan, a pathologist at Toledo Hospital, was a consultant at the meeting. Mrs. Millis assisted the hostess.

The Auxiliary members are well represented on the new Citizens Committee for Day Care for School Children. Mrs. Adelbert J. Kuehn was named chairman of the executive committee. Mrs. Carl Dreyer, public relations chairman. Mrs. Albert Bershon is chairman and Mrs. Richard Hatz co-chairman of the North End district. The Mental Hygiene Study Group met at the home of Mrs. R. P. Whitehead, Jr. John G. Field spoke on "Psychology of Minor Group."

An illustrated travel talk, "Seeing Europe by Jeep," was given by Mrs. Richard Drouard at the general membership meeting of the Auxiliary in the Academy of Medicine building. Mrs. Charles Forrester, member of the auxiliary's program committee, was in charge of arrangements.

Mrs. David T. Curtis and Mrs. William T. Preston, luncheon chairmen, were assisted by Mesdames: A. S. Avery, Paul Baehren, N. T. Barnes, George Bova, Thomas Bowles, John Dickie, Ned B. Hein, John Kozy, George Lemon,

William Meffley, Jack Millis, Joseph Radecki, Oliver Todd, Joseph Westhoven, Marvin Green, John Kelleher, Crawford Felker, Murray Goodrich, Wendell Green, Hazen Hauman, J. D. Huss, J. E. Minns, William Phillips and John Skow.

Mrs. Franklin Earnest III, chairman of the dance committee, had a committee meeting at her home in January. The committee included Mrs. William Newborn, social chairman; Mrs. Henry D. Cook, assistant dance chairman; Mrs. John Dickie, tickets and reservations; Mrs. W. H. Eyster, Jr., telephone; Mrs. Ralph Zucker, costumes; and Mrs. Samuel D. Zuker, food.

The Food and Decoration Committee included Mrs. Samuel Zuker, chairman, and Mesdames William Meffley, Carl Bayha, Stanley Andrews, Alfred Rhoden, John Erkert, William Phillips, Paul Orr, Russell Wahl, A. H. Steinberg, F. B. Hawkins, Spencer Northup, John Dickie.

MAHONING

Mrs. Morris S. Rosenblum, president, conducted the January meeting held in the Youngstown Club. After dinner the program chairman, Mrs. Frederick S. Coombs, introduced Mrs. Howard Burt who gave a review of Isabel Ross' story "Proud Kate." Miss Helen Craig sang solos and was accompanied by Mrs. John R. Hill. Mrs. Paul J. Fuzy, chairman of the social committee, arranged the party. She was assisted by Mrs. Richard R. Goldcamp, co-chairman, and by Mrs. John R. Renner and Mrs. James L. Smeltzer. It was voted to increase the pledge to the Medical Education Foundation. Recognition was given Mrs. Wayne Hardin, ways and means chairman, for assistance in the recent diabetic program and for support of the Heart Fund Drive.

"Through the Looking Glass" was the unique title for the style show dessert-tea and guest day arranged by the Auxiliary at Rodef Sholom Temple. The fashion display was presented in a series of "flashbacks," and featured, in addition to regular models, three "junior" models. Mrs. Harold Chevlen is chairman, and Mrs. David Brody and Mrs. James Smeltzer are co-chairmen. Reservations were made with Mrs. Frederick Resch who is the social chairman.

Mrs. Asher Randall and Mrs. Earl Young were in charge of the decorations, and pianist was Mrs. Ernest Gottesman. "Junior" models were Vickie Shorr, Diane Phillips and Frances Goudsmit, while other models included: Mesdames Paul Fuzy, Jr., George McKelvey, Sam Zlotnick, Stephen Ondash, John Noll, Elmore McNeal, Alfred Cukerbaum, J. L. Scarnecchia, John Stotler, Sidney C. Keyes, A. E. Rappaport, Paul Mahar, and W. B. Hardin.

MIAMI

An A. M. A. film, "Operation Herbert," illustrating the cost of medical care in comparison with other living expenses was shown at the January meeting held in the home of Mrs. George Woodhouse. Mrs. Dale Hudson, Mrs. Harry Shilling and Mrs. William Oakins were appointed delegates to the State Auxiliary meeting in Columbus in April. Mrs. Frank Maschmeyer, a member of the Cancer Drive Committee, gave a short talk on the need for volunteers. A committee was appointed to help with Mrs. C. M. Oxley as chairman to be assisted by Mrs. R. A. Reich and Mrs. Hugh Wellmeier. Mrs. George McCullough presided at the tea table. The film was shown to the group by Dr. Woodhouse.

Dr. John Quirk was guest speaker at the February meeting held at the home of Mrs. Wm. W. Trostel. "Functional Diseases of the Heart" was Dr. Quirk's subject. Mrs. Ralph Yates and Mrs. Berton Hogle assisted the hostess when tea was served.

MIAMI

At the March meeting, a luncheon at the Dettmar Hospital, new officers for the year were named. Mrs. J. E. Bausman was elected president; Mrs. Burton Hyde, president-elect; Mrs. E. G. Putterbaugh, vice-president; Mrs. R. A. Reich, secretary; and Mrs. Maynard Kiser, treasurer. Reports of nurse recruitment examinations were given and February issue of *Today's Health* was reviewed by Mrs. William Trostel. This is the third year that the auxiliary has made nurse recruitment its major project, but this year scholarships were given to two girls.

MONTGOMERY

The following is a letter from the Montgomery Auxiliary:

"In checking the credits and awards list in our board meeting yesterday, we discovered that our monthly reports have been given to the editors of the magazine and not to the Publicity Chairman. To make up for this omission on the part of the Montgomery County Auxiliary, I am sending a brief account of the meetings we have had thus far.

"Our September meeting was a Kaffe Klatch at the home of a member. This is becoming an annual affair and very well received. One clever idea which might be passed on to other groups was the use of school slates used as trays.

"The October meeting was the district meeting at the Biltmore Hotel and was a luncheon. As our speaker, we had the leading woman columnist on a local paper. The place cards at this luncheon were so very clever—doctor in a derby hat on a bike in the dress of that time.

"The November meeting was a dessert combined with a good book review. The Dayton State Hospital offered their recreation hall for this gathering.

"At Christmas we had a tea with music and a presentation of original poems by Mrs. Elmer Arn. The name tags were in the form of Christ-

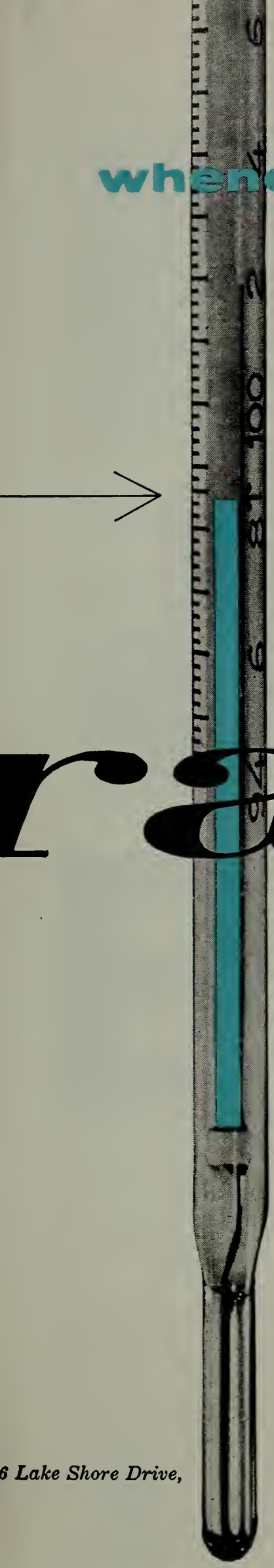
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*English, A. R., et al.: *Antibiotics Annual (1953-1954)*, New York, Medical Encyclopedia, Inc., 1953, p. 70.

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mas wreathes, ornaments and trees. Our January meeting was a luncheon with the speaker being Mrs. J. A. Mendelson.

"We estimate that we have had an average attendance of a hundred members for each meeting."

The Woman's Auxiliary of Montgomery County met at the Miami Hotel on Tuesday, January 12. The speaker, Mrs. J. A. Mendelson, spoke on "Customs of Old China." Mrs. Mendelson was with her husband, Dr. Mendelson, in China, where he was stationed with the Army and later engaged in private practice until the Chinese-Russian War began. During this time, Mrs. Mendelson accumulated many facts concerning the traditions of the Chinese which have been carried on in the same manner for thousands of years. She has published a few books and has material for more publications.

The tables were decorated with Chinese flower arrangements, large Chinese posters of Chinese sayings such as health, happiness, wealth, etc., and individual name cards with names written in a Chinese printing style. The meeting was cleverly different.

A Spring Style Show for the Auxiliary of Montgomery County was scheduled for February 25 at the Miami Hotel Auditorium. Thal's of Dayton planned to make this the nicest show for the Spring Season. Proceeds will go in the Nurse's Scholarship Fund.

The Auxiliary enjoyed a style show at its February meeting. Mrs. Sol Fishman was the accompanist. The committee that assisted Mrs. Harold Backhaven, chairman, were Mesdames R. L. Haas, L. C. Lolber, Robert Markey, R. E. Zipf, Herbert Insel, Morton E. Block, and C. B. Simson.

OTTAWA

The last meeting was held at the home of Mrs. C. R. Wood with Mrs. Robert Minnick as cohostess. During the meeting it was announced that Mrs. James Rhiel will be a delegate to the State Convention in April in Columbus. Mrs. George Boon was named alternate.

RICHLAND

Richland County Auxiliary held a luncheon meeting January 4 at the Woman's Club in Mansfield, Ohio.

During the business meeting, conducted by the president, Mrs. Paul Blackstone, the group voted to give $100.00 to the American Medical Education Foundation. Mrs. Donald DeWald, Legislative Chairman, gave a report on the legislative matter coming up in the current session of Congress affecting the Medical Profession.

Mrs. Paul Lee gave the 'highlights' of the party sponsored by the Auxiliary for "The Golden Age Club" at Christmas time. The Club is composed of 50 women over sixty-five years of age at the Friendly House. The program for the day was on nurse recruitment in Richland County and was prepared by Mrs. Myron Reed. Hostesses for the day were Mrs. L. A. Hautzenroder, Mrs. W. S. Kingsboro, Mrs. Alfred Adler, and Mrs. Ralph Wharton.

Annual Guest Meeting was held in Blymer Hall, Mansfield, Ohio, the evening of February 1 at 8 o'clock. Mrs. Paul A. Blackstone, President, welcomed 130 guests and members of the Auxiliary to the meeting. Mrs. Karl Langacher, Program Chairman, introduced the speaker Mr. Sewell Milliken, Chief, Division of Health Education, Ohio Department of Health, Columbus. A coffee hour was held after the meeting. The hostesses for the evening were Mrs. Wendell Bell, Chairman, Mrs. David Massa, Mrs. D. A. Adair, Mrs. J. A. Ellery, Mrs. R. D. Campbell.

A talk was given by Mrs. Robert Crawford on "Practical Nurses" at the March meeting, held at the Woman's Club.

The nominating committee comprised of Mesdames Carl Damron, Wilmot Pierce, and H. G. Knierim submitted the following slate of new officers: Mesdames Robert Crawford, president; Robert Pierce, president-elect; F. M. Wadsworth, vice-president; Paul J. Lee, treasurer; Hall Wiedemer, recording-secretary; Leonard Hautzenroder, corresponding secretary. Hostesses for the meeting were Mesdames Edward Beilstein, Albert Vaegele, Charles Brown, Jr., and L. D. Bonar.

SANDUSKY

The Auxiliary met January 12 in the home of Mrs. Frank L. Moore with Mrs. J. L. Curtin assisting hostess.

Mrs. Allen P. Newman presided over the business meeting during which donations were voted to the March of Dimes and the American Educational Fund. Changes to revise the constitution were read and approved by the group. A summary of Medical legislation in the state and national fields was given by Mrs. F. A. Vixconti, legislative chairman.

The program was a well-received round table discussion including reports on *Today's Health* and the "United Nations" by Mrs. H. L. Keiser. Mrs. E. C. Swint spoke on "Recent Developments in Medicine" and Mrs. L. A. Pokerr's topic was "The Care of the Medically Handicapped Children in Our Community." Refreshments were served at the close of the evening.

The February meeting was held in the home of Mrs. Carl J. Wolf. Mrs. W. J. Borth gave an interesting talk on her European trip made last fall. The business meeting was conducted by Mrs. Allan Newman. Mrs. Harold Keiser reported on sale of *Today's Health*. Mrs. Wolf was assisted by Mrs. Richard Wilson and Mrs. Merritt Huber.

SHELBY

The January meeting was held at the home of Mrs. J. F. Conner with Mrs. John H. Kerrigan

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presiding. It was reported that the refurnishing and redecorating of a room in Wilson Memorial Hospital, the project of the Auxiliary for the past year, has been completed. Mrs. George Schroer was elected delegate to attend the State Auxiliary meeting in April. Mrs. William Schroer was elected alternate.

SUMMIT

A round table discussion on "A Healthy Community Through Cooperation" headlined the January meeting of the Auxiliary. The panelists were representatives of various health agencies in the community. Mrs. Noah Miller was the moderator and the agency people were: Roger Sherman, Akron hospitals, Mary Knapp, nursing field, Wendell LaDue, Akron Water Department, Mrs. Helen Held, specialized health agencies, Robert L. Schaeffer, mental health, Mrs. Frances Hottenstein, public schools, and Carl Warmington, community planning agencies. This program served to introduce the Auxiliary's annual project "Health Days" to the public.

Mrs. Hubert Senne is serving as chairman of the seventh annual "Health Days." She is assisted by Mrs. E. C. Herschberger, floor plan, Mrs. Walter A. Hoyt, Jr., Mrs. G. W. Quinn, Mrs. Arthur Dobkin and Mrs. J. H. Pollack, interviewers, Mrs. E. W. Kissell and Mrs. Glenn Hough, publicity, Mrs. E. W. Cauffield, radio, Mrs. J. P. Sauvageot, adviser, and Mrs. Earl W. Burgner, schools. Fifty-one health agencies will exhibit for 3 days in the auditorium of one of Akron's downtown department stores.

TRUMBULL

Mrs. Wm. A. Tichnor was the guest speaker at the January luncheon meeting at the Trumbull Country Club. Her subject was "Mental Health."

TUSCARAWAS

At the February meeting Dr. George D. Woodward of the Mental Guidance Center at Union Hospital explained the functioning of the Center. Mrs. H. A. Coleman, at whose home the meeting was held, was assisted by Mrs. Robert Renderknecht and Mrs. Hahn. It was voted to give $25.00 to the Heart Fund and the same amount to the March of Dimes. A silent auction and Valentine exchange were held during the silent hour.

Officers chosen for the new year are: Mrs. Paul D. Hahn, president; Mrs. R. A. Wilson, vice-president; Mrs. E. L. Miller, president-elect; Mrs. Joseph Hamilton, treasurer; Mrs. George W. Johnston, secretary.

VAN WERT

At the January meeting held in the home of Mrs. F. W. Dornecker, the announcement of a new project, "The Babies Auxiliary," was made. Every baby born in Van Wert County Hospital will be invited to join the Babies Auxiliary and upon payment of $1.00 enrollment fee, will be presented a certificate and have his name placed on a scroll which will be hung in the hospital corridor. The money received from this project will be used to purchase necessary nursery equipment to improve the care of new babies.

A report of the Polio Foundation was made by Mr. R. P. Ranch and of the Cancer Society by Mr. F. R. German.

Sergeant Leonard Conn of the city police department, Mrs. Vera Johnson, secretary of the Red Cross, and Julian Gardner, representative of the Ohio Society for Crippled Children, were guest speakers at the March meeting. The meeting was held in the home of Mrs. C. A. Morgan. After the meeting, the hostess served refreshments during a social hour.

Vanishing parties, sponsored by the Auxiliary, as hospital benefits have been held the past several weeks. These are the results of the first parties given by Auxiliary members and the guests at the initial parties then entertained at parties for eight, and the guests at these parties entertain groups of four. Auxiliary members who started the parties were Mesdames R. W. Ayres, E. W. Burnes, J. H. Cox, F. W. Dannecker, O. J. Fatum, R. H. Good, J. R. Jarvis, C. A. Morgan, F. A. McCammon, and H. D. Underwood.

Members of the Van Wert County Hospital Board of Managers were guests of the Auxiliary at its February meeting in the Y. W. C. A. The speakers were Miss Marcile Spayd, Van Wert City Health Nurse, and Mrs. Esther Priddy, Van Wert County Health Nurse. The meeting was followed by a social hour and tea.

WASHINGTON

An informative report on pending congressional legislation of special interest to the medical profession was given by Mrs. W. S. Hawn following dinner at the Betsey Mills Club at the January meeting. During the business session,

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with Mrs. M. S. Muskat presiding, Mrs. Richard Hille was appointed delegate to the state convention in Columbus in April with Mrs. William R. Stewart, alternate. Mrs. R. M. Meredith was named mental health chairman. Mrs. David Thornburg, a new member, was welcomed by the group.

WASHINGTON

Miss Minoma Benson was the guest speaker at the February dinner meeting at the Betsey Mills Club. She told about conditions in England where she taught school during 1952-53.

103d Annual A. M. A. Meeting To Draw 12,000 Physicians

"California Here I Come" will be the theme of the more than 12,000 physicians who will attend the 103d annual meeting of the American Medical Association in San Francisco June 21-25.

Tentative plans for the world's largest medical convocation call for general scientific meetings to be held all day on Monday and on Tuesday morning, with the various scientific sections meeting on Tuesday afternoon, all day Wednesday and Thursday, and on Friday morning. All meetings will be held in buildings in the Civic Center area with the exception of the section on ophthalmology and a special Wednesday evening program, which will be held in the Terrace room of the Fairmont hotel.

Once again color telecasts of clinics and operations will be shown. They will originate from the San Francisco General Hospital and be received on two four-by-six-foot screens in the Masonic Temple. The latest and best medical motion pictures will be shown throughout the meeting at the Masonic Temple. The world première showing of some outstanding films of broad general interest will take place Wednesday evening in the Fairmont hotel.

Included in the approximately 200 Scientific Exhibits at the Civic Auditorium will be special features on fractures, blood banks, fresh pathology, preceptorships, pulmonary function testing, and question and answer conferences on cardiovascular diseases. In the Technical Exposition, also to be held in the auditorium, about 400 firms will show physicians the latest developments in new drugs, books, instruments, and other adjuncts to the practice of medicine.

A competitive examination for appointment of medical officers to the Regular Corps of the U. S. Public Health Service will be held June 1-3. Examinations will be given at a number of points. Additional information may be had from the Chief, Division of Personnel, Public Health Service, Department of Health, Education and Welfare, Washington 25, D. C.

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New Members of O.S.M.A.

The following are the names of new members of the Ohio State Medical Association since February 5, 1954. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ALLEN COUNTY
William Foxx, Lima
William G. Grannis, Lima
Emmett Murray, Jr., Lima
William E. Noble, Lima

AUGLAIZE COUNTY
Gordon L. Miles, St. Marys
Edward E. White, St. Marys

BELMONT COUNTY
William J. Johnson, Shadyside

CLINTON COUNTY
Robert M. Cronebaugh, Blanchester
Birt Harvey, Wilmington

CUYAHOGA COUNTY
Abdel R. Abla, Cleveland
Norman Bash, Cleveland
Milton F. Brown, Cleveland
Clayton E. Buhl, Cleveland
Charles N. Kavanaugh, Jr., Cleveland
Richard R. Patterson, Frederick W. Tillotson.
Ralph J. P. Wedgewood, Cleveland

DARKE COUNTY
Alfred E. Hollenberg, Hollansburg

FRANKLIN COUNTY
Tibor Agoston, Columbus
Dorothy S. Allen, Worthington
William F. Binkley, Columbus
Rozier E. Bland, Columbus
Joseph Robert Boyle, Columbus
Richard C. Brandes, Columbus
Robert L. Friedman, Columbus
Thomas F. Mancuso, Columbus
Lloyd K. Mark, Columbus
Charles V. Meckstroth, Columbus
Charles S. Myers, Jr., Columbus
John Porter Reed, Jr., Silver Springs, Md.

GUERNSEY COUNTY
Markian Migocki, Cambridge
Miroslaus Orlowsky, Byesville
Jonas Stankaitis, Cambridge

HANCOCK COUNTY
John F. Loyd, Findlay
Benjamin H. Saunders, Jr., Findlay

HIGHLAND COUNTY
Lawrence R. Cornelius, Greenfield

LICKING COUNTY
Jacob Araj, Newark

LORAIN COUNTY
Marvin M. Anderson, Lorain

LUCAS COUNTY
Robert J. Fredericks, Toledo
James C. Fries, Toledo
Margaret Lane, Toledo
E. Richard Marker, Jr., Toledo
Rexford Rutter, Toledo
Max F. Sudhoff, Toledo
Robert J. Taylor, Toledo
James R. Thompson, Toledo
J. Hugh Webb, Toledo

MAHONING COUNTY
Robert R. Fisher, Youngstown
Robert E. Glasgow, Youngstown

MONTGOMERY COUNTY
Robert W. Finch, Dayton
Carl H. Hall, Dayton
Sylvan L. Weinberg, Dayton
Philip A. Weisman, Dayton

PAULDING COUNTY
Gotholds Kalnins, Payne
Julian Movchan, Oakwood

PORTAGE COUNTY
David Palmstrom, Ravenna

RICHLAND COUNTY
Carroll E. Damron, Mansfield

SCIOTO COUNTY
Emmett J. Riordan, Portsmouth

STARK COUNTY
Samuel N. Abood, East Sparta
Shirley W. Gregory, North Canton
Robert J. Kuba, East Canton
John W. McFadden, Hartville
Mark F. Moots, North Canton
Leo W. Zadinsky, North Canton

WAYNE COUNTY
George J. Iten, Orrville

Dr. Frank B. Brewer, a medical official with the Veterans Administration and its predecessor agencies since 1921, has been appointed assistant chief medical director in charge of operations for V. A.'s 171 hospitals and domiciliaries, and 104 clinics. He succeeds Dr. Robert C. Cook, who plans to retire because of ill health.

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Ohio Physicians Certified in Aviation Medicine

Three Ohio civilian physicians and three medical officers formerly stationed in the State have been certified in aviation medicine, a new category of specialty authorized under the American Board of Preventive Medicine, Inc., according to information received from Dr. Ernest L. Stebbins, secretary-treasurer of the board.

They are: Dr. Richard L. Meiling, Columbus, associate dean of the Ohio State University College of Medicine; Dr. Thomas H. Sutherland, Marion; Dr. Herbert B. Wright, Cleveland; and the following medical officers formerly stationed at Wright-Patterson Air Force Base: Brig. General Otis B. Schreuder (retired), now medical director, Pan American Airways; Colonel Robert H. Blount, now assistant Air Force attaché U. S. Embassy, Paris; and Commander Harald A. Smedal, M. C., U. S. Navy.

These six physicians have been certified in the original "Founders Group" in aviation medicine. The list does not include others who have been considered by the Board as eligible for examinations for certification, Dr. Stebbins pointed out. Date for the first examination had not been set when this issue went to press.

Dr. White To Speak on Hand Surgery At Muskingum County Meeting

Dr. William L. White, assistant professor of surgery in the Department of Surgery, University of Pittsburgh, will be guest speaker for the Tuesday, April 6, meeting of the Muskingum County Academy of Medicine. The meeting will be held at 8:30 p. m. in the Zanesville Country Club, Zanesville.

Dr. White received his medical degree at Jefferson Medical College, Philadelphia, and served his internship at the Pennsylvania Hospital, Philadelphia. He served three years with the Harrison Department of Surgical Research, and during this time for a year was in Akron as director of a research project sponsored by the National Research Council, on the use of sulfonamides in acute traumatic surgery, as related to the development of infection. He served 21 months in the U. S. Navy in Philadelphia, during which time he worked with surgical infections in the field of orthopedics, rehabilitation of amputees and plastic and reconstruction surgery.

His subject at the Muskingum meeting will be "Hand Surgery."

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Medical History Group To Meet May 1

A meeting of the Ohio Academy of Medical History will be held at 1 P.M. on May 1 in the Ohio State Museum, at 15th Ave. and High St., on the O.S.U. Campus, Columbus.

Scheduled speakers and their subjects are as follows:

Mr. Adolph Waller, "An Ohio Physician Botanist."

Dr. H. H. Fertig, "Some Letters of Jared Potter Kirtland."

Dr. Robert Preston, "Comparison of the Text of Noah Worcester and That of Robert Willan."

Dr. A. T. Bunts, "Leaves From an Ohio Doctor's Scrap Book."

Dr. Howard Dittrick, "A Still Life Painting Depicting Interests of a Cleveland Physician of the Nineties."

Dr. Leon Goldman, "Bell's Palsy in Ancient and Modern Art."

Dr. C. D. Selby, "Ohio's Contribution to Industrial Medicine."

Dr. H. D. Piercy, "Shaker Medicine."

Conference on Health in Colleges To Be Held in New York

The Fourth National Conference on Health in Colleges will be held in New York City at the Hotel Statler, May 5-8. Among Ohio physicians who are active in planning the conference is Dr. Max Durfee, Oberlin College, who is chairman of the Committee on Special Health Problems of Students.

Sponsors of the conference include more than 45 of the top national health organizations. Additional information may be obtained from the Ohio Tuberculosis and Health Association, 1575 Neil Ave., Columbus, or other of the health associations.

Cincinnati General Physicians Give Program on Skin Diseases

The Southwestern Ohio Society of General Physicians in collaboration with the University of Cincinnati College of Medicine sponsored a seminar on "Treatment of Diseases of Skin" on March 14 at the Alms Hotel, Cincinnati.

Speakers on the program included the following: Dr. S. William Becker, clinical professor of dermatology, University of Chicago; Dr. I. Edward Gaul, Evansville, Ind.; Dr. Dan J. Kindel, assistant professor of dermatology, University of Cincinnati; Dr. Alfred L. Weiner, assistant professor of dermatology, University of Cincinnati. Dr. Leon Goldman, professor of dermatology, University of Cincinnati, was moderator.

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GYNECOLOGY & OBSTETRICS—Gynecology Course, two weeks, June 7. Vaginal Approach to Pelvic Surgery, one week, May 24. Combined Course in Gynecology & Obstetrics, three weeks, April 19.

MEDICINE—Two-Week Course, May 3. Electrocardiography & Heart Disease, two weeks, July 12. Gastroenterology, two weeks, May 17. Hematology, one week, June 14.

DERMATOLOGY—Two-Week Course, May 10.

PEDIATRICS—Congenital & Rheumatic Heart Disease in Infants & Children, one week, April 19 and April 26. Cerebral Palsy, two weeks, June 14.

UROLOGY—Two-Week Course, April 19. Ten-Day Practical Course in Cystoscopy every two weeks.

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Western Reserve Opens Unique Law-Medicine Center

Western Reserve University has established a law-medicine center, said to be the first of its kind in the country, according to an article in *The Cleveland Plain Dealer* over the by-line of George J. Barmann.

President John S. Millis, of Western Reserve, in announcing the center said that Coroner Samuel R. Gerber had played a key role in creating the program, "dedicated to the better use of medical science in the administration of justice, both civil and criminal."

The new program involves law, medicine, police science, forensic pathology, forensic toxicology and science survey. Research, instruction and publication of findings will be a part of each of these specific classifications of study.

The center will not be a building, but many buildings on the University Circle campus. It will not be a faculty, but many faculties drawn from Western Reserve and the adjoining Case Institute of Technology, the coroner's office and public and private groups in Greater Cleveland. It will draw students from many sections—lawyers, doctors, prosecutors, law enforcement officers, businessmen, judges, coroners and others.

Representatives of industry and labor also will make use of the center facilities and experts. Significant in establishment of the center was location of the coroner's office on the campus last year.

Oliver C. Schroeder, Jr., associate professor of law and director of the graduate law program, said that leadership within the university for the center has come from the law faculty. At Harvard and Johns Hopkins, he pointed out, leadership comes from the medical school.

All of the physical facilities and professional staff are located in one geographic area—coroner's office, law school, medical school, Institute of Pathology, university science buildings, including the proposed $2,500,000 science center, plus facilities and faculty of Case Institute.

Dr. Gerber stressed the need for better integration of law and medicine. Justice is dependent to a greater or lesser degree on medical evidence in about one half of all cases reaching the appellate courts, he declared.

Dr. Gerber listed the following objectives of the center:

To instruct law students and law-enforcement officers in the proper utilization of medical and scientific evidence.

To train medical students, doctors and chemists in acquisition, preservation and interpretation of evidence in various scientific fields.

To study and report on legal procedures by which the courts will have the benefit of competent, nonpartisan expert opinion when such

opinion is needed for appraisal of scientific evidence.

To devise and report legislation to improve the competence with which medical and other scientific facts are gathered in situations which are likely to result in litigation.

To study and report on crime, its causes, detection, solution, punishment and prevention.

Rule "No Conspiracy" on Part of A. M. A. in Krebiozen Case

An Illinois legislative commission, which has been investigating the krebiozen controversy off and on since last April, ruled recently that there was no "conspiracy" on the part of the American Medical Association, the Chicago Medical Society and the University of Illinois against the so-called cancer drug.

The legislative hearing stemmed from charges by Dr. Andrew C. Ivy that there was a conspiracy to oust him from his post as vice-president in charge of professional colleges at the University of Illinois and to ruin him professionally because of his research into krebiozen.

The A. M. A. contended all along that the drug was worthless in the treatment of cancer.

While a commission statement specifically absolved the A. M. A., no mention was made by Dr. J. J. Moore, pathologist, and treasurer of the A. M. A., and two Chicago business men who were accused specifically of trying to gain "distribution rights" to krebiozen in the United States.

Representative William E. Polack, chairman of the 14-man commission, said rulings would be made on individuals after additional evidence is presented by their counsel.

Dr. Moore has contended that Dr. Ivy's charges that he aided the two Chicago business men in trying to gain "distribution rights" for the drug were ridiculous and without foundation.

A. M. A. Committee Appointed

At the last Clinical Session of the A. M. A., the House of Delegates adopted a resolution calling for the appointment by the Board of Trustees of a "special committee with broad representation throughout the profession" to study "all aspects of the problems of public relations created by recent adverse publicity."

The following persons have been appointed to that committee, with possibility of two others being added: Drs. Stanley R. Truman, chairman, Oakland, Calif.; John S. DeTar, Milan, Mich.; Leland S. McKittrick, Brookline, Mass.; James Q. Graves, Monroe, La.; and Felix L. Butte, Dallas.

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LOCUM TENENS for Cleveland, neighboring cities, Sept. '54. 1 mo., Ohio license. Completing first year residency Internal Medicine at University Hospital. State salary, living conditions. Write G. Seltzer, M. D., 419 N. State St., Apt. 5, Ann Arbor, Mich.

GENERAL PRACTICE GROUP: Excellent opportunity in small north-central Ohio town with large surrounding territory (about 4,000). Two well-established and over-worked practitioners until April 1 when older physician retires. Remaining man wants to start clinic for 3-man group. No money needed. Full partnership after 1 yr. Only 12 miles to 2 excellent hospitals. Write Box 768, c/o Ohio State Medical Journal.

FULLY EQUIPPED OFFICE for rent for general practice, south end of Columbus. Box 770, c/o Ohio State Medical Journal.

FOR SALE: Cambridge "Simpli-Trol" Model Portable Electrocardiograph. Excellent condition. $100. W. H. Miller, M.D., 328 E. State St., Columbus, Ohio, MAin 3743.

Dover—The following physicians were named officers of the medical staff of Union Hospital: Dr. R. I. Oyer, Sugarcreek, president; Dr. Paul W. Ebert, Dover, vice-president, and Dr. Philip Doughten, New Philadelphia, reelected secretary-treasurer.

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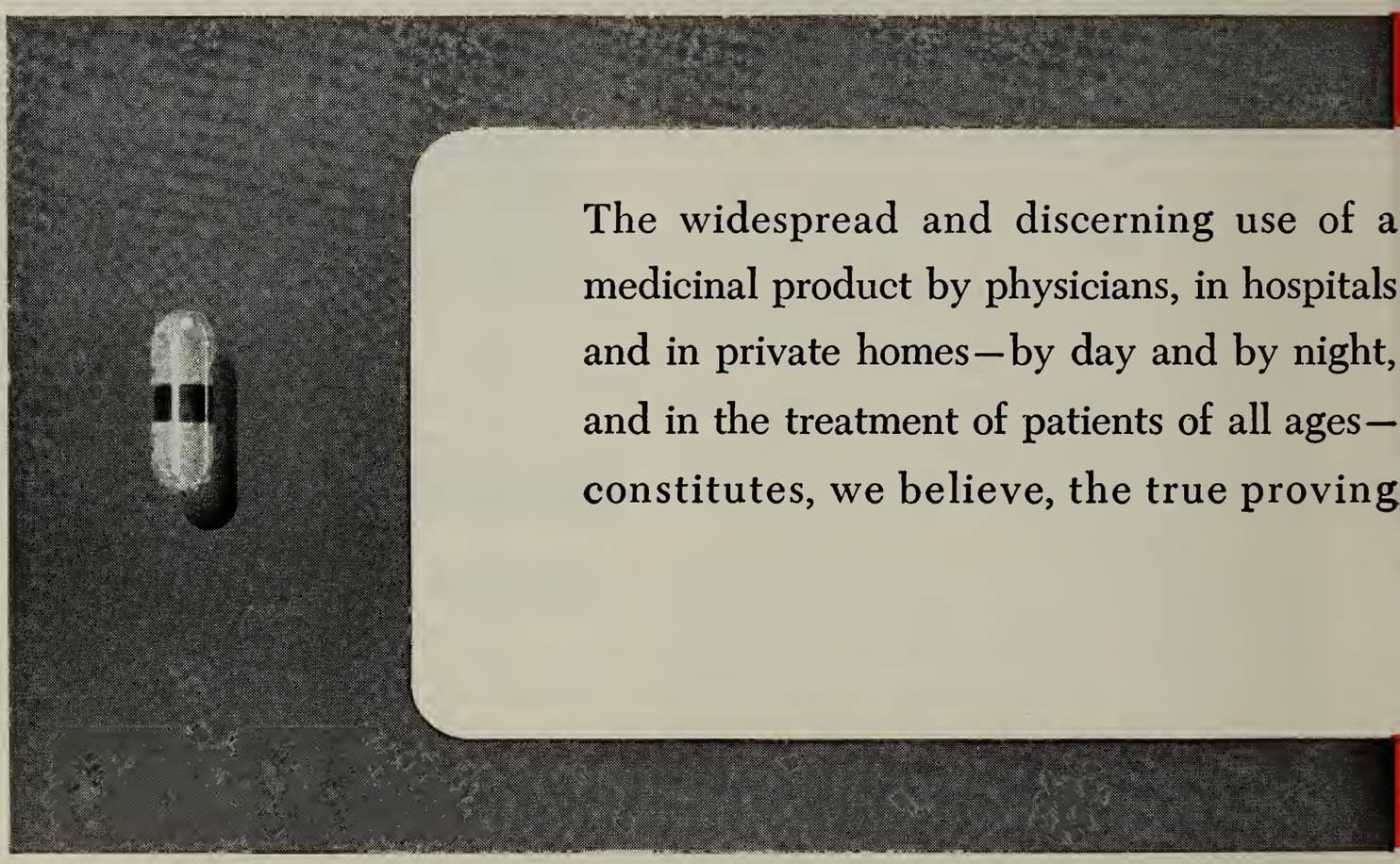
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

The Acquisition of Word Meanings: A Developmental Study, by Heinz Werner and Edith Kaplan. (A Monograph of *The Society for Research in Child Development, Fayerweather Hall, East, Northwestern University, Evanston, Ill.)*. Generally, between the ages of nine months and one and a half years the child crosses the threshold of human speech. He comes to understand that sound patterns are not merely **signs** directing human behavior but actually are **symbols** representing objects or events. From here the child must pass through several stages of symbolic behavior before he reaches a mature level of "abstract symbolism." The child acquires the meaning of words principally in one of two ways. One is by explicit reference either verbal or objective; he learns to understand verbal symbols through the adult's direct naming of objects or through verbal definition. The second way is through implicit or contextual reference; the meaning of a word is grasped in the course of a conversation, i. e., it is inferred from cues of the verbal context. This study investigates experimentally the processes underlying the acquisition of word meaning through verbal context.

Factors in Intelligence and Achievement, by the Reverend Justin A. Driscoll, ($1.00. *The Catholic University of America Press, Washington 17, D. C.)*. This is a study of the factor pattern resulting from analysis of the scores of boys in junior high school on intelligence and achievement tests.

New Means of Studying Color Blindness and Normal Foveal Color Vision with Some Results and Their Genetical Implications, by Gordon L. Walls and Ravenna W. Mathews, ($2.50 paper. *University of California Press, Berkeley, Calif.)*. The three-component theory of color vision is accepted. Nothing is found to conflict with the supposition that the basis of each hereditary type of color blindness is retinal and receptoral. The text goes on to present 63 other important technical conclusions and their proof.

Cook Book for Beginners (A Cook Book for Brides), by Dorothy Malone, (35¢. *Ace Books, Inc., 23 West 47th Street, New York 36, N. Y.)*. Notices of good inexpensive cook books do have a place in this department because food acceptance is the No. 1 health problem of the American people. There is no use in preaching a good diet unless the individual citizen will accept it. The average person will accept it if it is properly and tastily prepared and attractively served. This is where this little book comes in, for it gives clear and understandable directions for doing just that.

Communicable Diseases — A Textbook for Nurses, by Albert G. Bower, M. D., and Edith B. Pilant, R. N., ($5.50. *W. B. Saunders Co., Philadelphia 5, Pa.)*. This is the seventh edition of this well-known text. It has been entirely rewritten with much new material added.

Psychotic and Neurotic Illnesses in Twins, by Eliot Slater, with the assistance of James Shields, British Medical Research Council Special Report No. 278, ($4.75, from *British Information Service, 30 Rockefeller Plaza, New York City, N. Y.)*. This is a definite contribution to the fundamental analysis of human behavior. The problem always resolves itself into determining how far man's nature is the inescapable corollary of his inheritance and how far it is the result of the varied experiences which he has undergone since birth. This study of the personalities of twins in all clinical groups shows that the basic make-up of the personality is largely determined by heredity.

Films in Psychiatry, Psychology, and Mental Health, by Adolf Nichtenhauser, M. D., Marie Coleman, and David White, M. D., ($..... *Health Education Council, New York and Minneapolis)*. The aims of this unique book are first to make films in this field more useful to more people; and, second, to begin to set higher standards of quality for making better films in the future of this important area of medicine. It is therefore a book that all workers in the fields will want to read and have as a reference.

The Making of a Scientist, by Anne Roe, ($3.75. *Dodd, Mead and Company, New York 16, N. Y.)*. The eminent psychologist, Anne Roe, selected 64 of the foremost scientists and devoted three full years to testing and analyzing their careers. In most things these men proved to be even as you and I, but at one point or another their lives took a very special turn leading them to success and esteem in their chosen fields of science.

New and Nonofficial Remedies—1953, Accepted by the Council on Pharmacy and Chemistry of the A. M. A., ($3.00. *J. B. Lippincott Co., Philadelphia 5, Pa.)*. This is the current report on many useful but unofficial drugs. It is complete. It is accurate. It represents what the physician wants to know about the newer remedies.

Peripheral Nerve Injuries—Principles and Diagnosis, by Webb Haymaker, M. D., and Barnes Woodhall, M. D., ($7.00. Second Edition. *W. B. Saunders Co., Philadelphia 5, Pa.)*. The success of the neurosurgeon, the orthopedic surgeon, and the physical therapist working together as a team

to return the victims of this type of injury to full duty, depends to a large extent upon the early recognition of the nature of such injuries. This monograph which has undergone extensive revision is especially welcome for the clear and terse way in which it deals with their diagnosis.

Surgery of The Pancreas, by Richard B. Cattell, M. D., and Kenneth W. Warren, M. D., ($10.00. *W. B. Saunders Co., Philadelphia, Pa.).* This pioneering monograph's conclusions can be trusted for they have been built upon considerable experience which has been carefully analyzed for the benefit of surgeons in general.

The Grassi Block Substitution Test for Measuring Organic Brain Pathology, by Joseph R. Grassi, M. A., ($3.00. *Charles C. Thomas, Springfield, Ill.).* A monograph in the American Lecture Series. The text is primarily concerned with presenting a test battery composed of instruments tapping as many different areas as possible in order to investigate as many areas of dysfunction as possible.

Hypersplenism, by Cyrus C. Sturgis, M. D., ($3.25. *Charles C. Thomas, Publishers, Springfield, Ill.).* A clinical evaluation by the professor of medicine at the University of Michigan originally presented as a Beaumont Lecture.

Periodontia, by Henry M. Goldman, D. M. D., ($16.00. Third Edition. *The C. V. Mosby Co., St. Louis 3, Mo.).* This is an up-to-date study of the histology, physiology and pathology of the periodontium and the treatment of its diseases. With all of the flurry to get a short cut remedy for dental caries, especially the high powered, gimmick ridden campaign for fluoridation of public water supplies, we are apt to forget that these diseases of the periodontium are of equal if not greater importance. This book is therefore one that all physicians who are interested in what happens in the mouth after one reaches adulthood will want to read.

The Troubled Mind, by Beulah Chamberlain Bosselman, M. D., ($3.50. *The Ronald Press Co., New York 10, N. Y.).* In treating serious personality disorders the best is often not good enough. This author, however, believes that the informed layman can do a great deal to understand and alleviate the emotional disorders of himself and others. Hence this volume.

Microbes at Work, by Millicent E. Selsam, illustrated by Helen Ludwig, ($2.00. *Wm. Morrow & Company, New York 16, N. Y.).* Here the young reader will find not only the work of pathogenic micro-organisms, but also how the friendly ones work. Without germs we would have no cheese, no pickles, no bread and none of the antibiotics. Accurate and informative illustrations greatly increase the book's value to the young readers.

Physiologic Effects of Wounds, by The Board for the Study of the Severely Wounded, North African - Mediterranean Theater of Operations, ($3.50. *Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.).* What we have here is essentially a physiologic atlas of the severely wounded—not in illustration, but on illustrative data. All who are interested in what traumatic injury does to organic function will want to read this historic work.

The Book of Health, compiled and edited by Randolph Lee Clark, Jr., M. D., and Russell W. Cumley, Ph. D., ($10.00. *Elsevier Press Inc., New York 28, N. Y.).* Family Doctor Books were commonly popular from 1830 to 1895. Since that time medical progress has been too fast to allow them to gain much popularity. Here is a book that should change the trend. Under careful editorship 242 physicians set forth in popular language what they believe the layman and his family should know about medicine. Among the contributors are the following Ohio physicians: Drs. George Crile, Jr., and Irvine H. Page, of Cleveland; Charles A. Doan and John D. Porterfield, of Columbus; and Ashton L. Welsh of Cincinnati. This work should accomplish its basic purpose, i. e., to give the public the clearest and most complete medical information available, thus supplementing or correcting the information which the layman now thinks that he has.

Man's Back, by Theodore A. Willis, M. D., ($9.50. *The Charles C. Thomas Co., Springfield, Ill.).* Based upon extensive experience, as most of our members know, the author teaches us how to differentiate the various types of backache and how to correlate them with injury and disease. The text is supported by 210 excellent illustrations of high technical quality. It is a book that will be useful to every physician who is concerned, at one time or another, with backaches—and who isn't?

This Hospital Business of Ours—A Guide Book for Hospital Trustees, Hospital Workers and Laymen, by Raymond Paton Sloan, ($4.50. *G. P. Putnam's Sons, New York 16, N. Y.).* A book designed to interpret the American Hospital to the general public.

Understanding Your Teen-Ager. Guidance to parents of teen-age children. Just published by and available without charge from Metropolitan Life Insurance Company, One Madison Ave., New York 10, N. Y.

Malpractice and the Physician Committee on Medicolegal Problems. A pamphlet dealing with malpractice claims, emphasizing the preventive aspects of the problem and containing many suggestions—18 pages. Available for 25 cents from American Medical Association, 535 North Dearborn St., Chicago 10.

Meats-in-a-Can

and Kitchen-Cooked Meats...
Comparative Nutritive Values

From a practical dietary standpoint, meats-in-a-can—preserved by commercial canning—are nutritionally interchangeable with meats of like variety prepared in the home.[1] For taste appeal, for economy and "keeping" quality, and for household convenience, meats-in-a-can are advantageous in many respects.

As the comparative data here shown indicate, kitchen-prepared meats and similar meats-in-a-can are closely alike in the amounts of various nutrients they provide.

COMPARATIVE COMPOSITION OF KITCHEN-COOKED AND COMMERCIAL-CANNED MEATS
(Nutrient Amounts per 100 Grams)

	*Kitchen-Cooked Ham[2]	**Canned Ham[3] (Chopped, Cured)	Kitchen-Cooked Beef Round[2]	Canned Roast Beef[2]
Water	50%	50%	59%	60%
Protein	21 Gm.	20 Gm.	27 Gm.	25 Gm.
Fat (ether extract)	28 Gm.	20 Gm.	13 Gm.	13 Gm.
Niacin	4.0 mg.	4.3 mg.	5.5 mg.	4.2 mg.
Riboflavin	0.21 mg.	0.19 mg.	0.22 mg.	0.23 mg.
Thiamine	0.46 mg.	0.40 mg.	0.08 mg.	0.02 mg.

*Values after conversion from 42% to 50% water basis.
**Values after conversion from 58.69% to 50% water basis.

Experimental studies have shown that the processing which meats-in-a-can undergo leads to little if any greater vitamin losses than does home-cooking of similar cuts of meat. In general, meats-in-a-can retain of their original vitamin content approximately:

60 to 80 per cent of thiamine
90 to 100 per cent of riboflavin
90 to 100 per cent of niacin
80 per cent of biotin
70 to 80 per cent of pantothenic acid.[4,5]

During storage for customary periods, at usual warehouse temperatures, meats-in-a-can show little, if any, further vitamin loss except in thiamine. Even thiamine, a highly thermolabile vitamin, was 52 per cent retained in pork-in-a-can after ten months' storage at 80° F. Retention of the vitamin was notably greater when the canned pork was stored at 38° F.

Since meats-in-a-can are thoroughly cooked in processing, they may be consumed as purchased, merely warmed or mildly cooked. When the meat is moderately cooked in preparation for consumption, little or no further loss in vitamins need to occur.

Recent studies show that meats-in-a-can are excellent sources of needed amino acids.[6] The 18 amino acids determined in these studies appeared in similar ratio and amounts in canned beef, pork, and lamb as in the respective fresh or home-cooked meats.

1. Howe, P. E.: Foods of Animal Origin, Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 637.

2. Watt, B. K., and Merrill, A. L.: Agricultural Handbook No. 8, United States Department of Agriculture, 1950.

3. Schweigert, B. S.; Bennett, B. A.; Marquette, M.; Scheid, H. E., and McBride, B. H.: Food Res. *17*:56 (Jan.) 1952.

4. Rice, E. E., and Robinson, H. E.: Am. J. Pub. Health *34*:587 (June) 1944.

5. Schweigert, B. S.: Am. Meat Inst. Foundation, Circular No. 8, Nov. 1953.

6. Schweigert, B. S.; Bennett, B. A.; McBride, B. H., and Guthneck, B. T.: J. Am. Dietet. A. *28*:23 (Jan.) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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Vol. 50 May, 1954 No. 5

JONATHAN FORMAN, M. D., *Editor*

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Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Sliding Hernia: Experiences With Thirty-Three Cases With a Report of Two Cases in Infants

FRANK J. RACK, M. D., and EDWARD A. WEBB, M. D.

SLIDING hernia is best described as a hernia in which some portion of the wall is formed by a viscus which in its normal position is only partly covered by peritoneum[1]; thus, bladder, cecum, ascending colon, descending colon or sigmoid may be contained in a sliding hernia.

The problems of repair in this type of hernia are many. Cole and Elman aptly state that the operative repair is usually difficult and that if the hernia is small the lack of a sac may lead the surgeon into the error of mistaking the colon for the sac and opening the colon.[2] They suggest that after mobilization of the colon and separation of the adhesions betwen the colon and sac it is frequently advisable to anchor the colon to the posterior wall of the pelvis.

If this is done in a large hernia the blood supply to the colon may be completely destroyed. Bisgard states that one need only mobilize the bowel sufficiently to make possible its return through the internal ring and to repair the inguinal canal by one of the several methods used for inguinal hernias.[3] He adds, however that the recurrence rate for this type of hernia is from 10 to 40 per cent.

There is also disagreement regarding the surgical approach to the repair of a sliding hernia. Crily,[4] David,[5] Bevan[6] and Burton and Blotner[7] advocate repair of a sliding hernia from an inguinal incision, whereas Jacobson,[8] LaRoque,[9] Graham,[10] Brown,[11] William[12] and Moschowitz[13] recommend the use of an abdominal incision, either alone, or in addition to the inguinal incision. In a survey of members of the Southern Surgical Association, Williams[12] found that 69 surgeons always used an abdominal approach, 15 occasionally used an abdominal approach and 156 members usually repaired a sliding hernia from an inguinal incision alone.

From the Department of Surgery, School of Medicine, Western Reserve University and Cleveland City Hospital.
Submitted October 26, 1953.

The Authors

● Dr. Rack, Cleveland, is assistant visiting surgeon, Cleveland City Hospital; senior instructor in surgery, School of Medicine, Western Reserve University.

● Dr. Webb, Ravenna, Ohio, is a member of the surgical staffs at Robinson Memorial Hospital, Ravenna; and Marymount Hospital, Cleveland.

MATERIAL STUDIED

This somewhat confused situation led us to attempt an evaluation of the various techniques for the repair of sliding hernia and the subsequent results in a series of 33 consecutive sliding hernias repaired at Cleveland City Hospital from January 1, 1940, to January 1, 1953.

All of the patients were males and ranged from 17 months to 85 years of age (Table 1). Because of the rarity of sliding hernias in children the youngest two patients in this series are reported in some detail. Sixteen of the hernias were re-

ducible preoperatively; the other 17 were incarcerated. Six of the latter group were treated by emergency operation because strangulation could not be eliminated. One patient had gangrene of the entire right colon and distal ileum secondary to strangulation. Five patients had previous hernia repairs and two of this group each had two previous herniorrhaphies.

Three general techniques were used in this series. An inguinal incision was employed in 23 of the cases. An inguinal incision supplemented by an abdominal incision was used in nine other cases. In one patient, the repair was done through a McBurney muscle splitting incision, no inguinal incision was made.

TABLE I. AGE INCIDENCE OF SLIDING HERNIA

Age in years	Incidence
0-10	2
31-40	2
41-50	3
51-60	9
61-70	11
71-80	5
81-90	1

Orchidectomy was done incidental to the repair in 11 cases. An incidental appendectomy was performed five times. This did not result in any postoperative complications. During surgery the outer layers of the bowel wall were accidentally incised in four patients and in one other patient the bowel lumen was entered inadvertently.

Postoperative complications occurred in 13 of the 33 cases. Among the complications were the accumulation of scrotal fluid, scrotal swelling and wound hematoma in two patients each. Two patients developed draining sinuses which were slow to heal. Two patients died in the immediate postoperative period. One patient had a resection of a gangrenous right colon and died after herniorrhaphy on the first postoperative day. The other death was an 85 year old man whose inguinal hernia was producing large bowel obstruction and who died four days after herniorrhaphy in cardiac failure.

Thirty-one patients survived the operation. Twenty-three were available for examination from one to 108 months postoperatively. Three recurrent hernias were found in this group. This represents a mortality rate of 6 per cent and a recurrence rate of 12 per cent.

DISCUSSION

The predominance of males is to be expected in any series of sliding hernias as in the female the absence of a spermatic cord usually protects the internal ring from massive enlargement. It is of interest to note that sliding hernia occurs in infants and children. David was first to report three cases and we have added two more. The occurrence in white males is greater than anticipated from the usual racial distribution in this hospital. As in other reports left sided hernias predominate.[7]

The typical history obtained from patients with sliding hernia is the awareness of a hernia which rapidly becomes larger. These patients are unable to maintain reduction of the hernia with a truss and, in addition, wearing the truss is usually painful. On physical examination the hernia is frequently in the scrotum and is difficult and painful to reduce. A definite preoperative diagnosis can be made by use of the barium enema. This was done once in this series. Our experience is the same as others;[7] in 47 per cent of the cases the hernia was irreducible.

Fifteen per cent of the patients in this series had previous inguinal herniorrhaphies. Invariably if the presence of a sliding hernia is not recognized during simple herniorrhaphy a recurrence will result. Two recurrences resulted in this series in patients in whom only an inguinal incision was made, the sac reduced and a Bassini repair done. The other recurrence was in a patient in whom a LaRoque incision was made and the cecum and appendix returned to the peritoneal cavity proper through the second muscle splitting incision without the creation of a mesentery for the cecum. A McVay repair was done for the inguinal defect.[13] This hernia recurred within one month after operation.

Of the 23 patients in whom only an inguinal repair was done 15 were available for follow-up study. There were two recurrences in this group (13 per cent). Among the remaining eight patients who were operated upon through an inguinal and abdominal approach only one recurrence developed. None of the five patients who underwent orchidectomy developed a recurrence.

There are few accurate follow-up studies of operative repair of sliding hernia. In 1942 Burton and Blotner reported on 27 cases personally operated upon and re-examined. In that series there were two recurrences (7 per cent). They advocated a "fishmouth" type of repair from an inguinal approach using half of the sac which did not contain bowel to overlap the freed and reduced sliding loop of intestine. This procedure was followed by a Halsted type of repair.

Inguinal herniorrhaphy is a common surgical operation and since from 1 to 3 per cent of all hernias are of the sliding variety, difficult of preoperative diagnosis, the surgeon must be mindful of the possible presence of this type during every herniorrhaphy. If its presence is not realized the development of fecal fistulas, peritonitis and high recurrence rates will be inevitable.

SURGICAL TECHNIQUE

In effective repair of a sliding hernia attention must be directed to four factors. First, the bowel present in association with the sac must be returned to the peritoneal cavity and, secondly, provision must be made for it to remain there.

Reduction of the bowel may be done either from the inguinal incision or from a second incision made through the muscles of the abdominal wall allowing reduction from within the peritoneal cavity. Following this, to prevent a recurrence, attention must be directed towards creating a mesentery for the bowel. This, likewise, may be done from the inguinal incision as suggested by Bevan. The experience reported above, however, indicates that reduction of the bowel is more accurate and reconstruction of the mesentery is more effective when done from within the peritoneal cavity.

Thirdly, the large inguinal ring usually present in association with sliding hernias must be repaired. Data are insufficient to permit a definite statement regarding the type of herniorrhaphy to be done. Either a Halsted or Bassini type of repair seems to be effective. The McVay type of inguinal canal repair provides the best reconstruction where one is dealing with a large defect in the floor of the inguinal canal.

Lastly, from experience in patients in the older age groups, the problem of sliding hernia repair can be much simplified if orchidectomy is done along with removal of a liberal portion of the spermatic cord. When this is possible reduction of the hernia from the inguinal incision followed by tight and complete closure of the inguinal ring provides an effective repair with few if any recurrences.

CASE REPORTS

Case 1. The patient, a 17 month old white male, was admitted to City Hospital of Cleveland with a history of swelling of the right groin present since 3 weeks of age. The swelling had increased progressively in size. It was always reducible without pain. The remainder of the history was not contributory.

Physical examination was not remarkable except for a large mass which completely filled the right compartment of the scrotum. This mass was separate from the right testicle and did not transilluminate light. Bowel sounds could be heard over the mass. The mass was easily reducible revealing a two finger defect of the inguinal ring.

At operation the posterior wall of the sac consisted of the tip of the cecum and appendix. The appendix was removed and the sac was closed over the tip of the cecum. The mass was reduced through the internal ring and a Bassini repair was performed. This patient was not available for follow-up.

Case 2. The patient, a two year old colored male, was admitted to City Hospital of Cleveland with a reducible inguinal swelling of six months' duration.

Physical examination revealed an easily reducible left inguinal hernia.

At operation the sigmoid colon was found to occupy the lateral wall of the hernial sac. The upper skin flap was retracted and a muscle splitting incision was made to enter the peritoneal cavity. The hernial sac was reduced into the peritoneal cavity. The mesentery was recreated with chromic catgut sutures. The muscle splitting incision was closed and a Bassini repair was done for the inguinal defect.

The postoperative course was uneventful. No evidence of recurrence was found 10 months after the operation.

SUMMARY

1. A series of 33 sliding hernias is reported with a mortality rate of 6 per cent and a recurrence rate of 12 per cent.

2. Effective repair of a sliding hernia requires attention to four factors:

(a) Reduction of bowel to the peritoneal cavity;
(b) Re-creation of a mesentery for the involved bowel;
(c) Repair of the large inguinal ring and
(d) Orchidectomy, if possible, for the best results.

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Hematuria May Be First Symptom of Death

Hematuria, which is gross or microscopic and occurs in the urine initially, terminally, or throughout the urinary stream, is an omen of great importance and often serious. Recurrent hematuria irrespective of the interval between episodes may be the first symptom of death.

Every patient with hematuria should have a complete urological examination and, if necessary, repeated examination until a definite diagnosis is firmly and irrevocably established. Generally, the old rule of painful hematuria being inflammatory while painless hematuria is cancer is true, however, painful hematuria may be renal tuberculosis.

Early diagnosis and surgical therapy may mean the difference between life and death, and even more important the difference between comfort and seemingly endless days of urinary agony.—Robert Lich, Jr., M.D., Louisville, Ky; *J. Indiana State M.A.*, 47:137, February, 1954.

KEEPING UP WITH MEDICINE

• ARETAEUS, a Roman physician of about A.D. 200, wrote a description of a disease to which he gave the name diabetes; "It consists of a liquefaction of the flesh and bones into urine . . . It is just as though the aqueducts were wide open."

* * *

• IN THE USE of any reducing diet, or calorie restriction, it is most important to see that there is an abundant supply of proteins, vitamins, and minerals. It is also more difficult to get enough of the protective factors when eating a lower total quantity of food. The choice of foods, therefore, on a reducing program has to be watched more carefully.

* * *

• FOOD PROBLEMS seem to have bothered the ancient Egyptian, for there is papyrus written about 3400 B. C. singing praises to the Supreme Sun God, Ptah: "And thus the official positions were made and the functions of government were assayed which furnished all nutrition and all food."

* * *

• THERE ARE several reports indicating that fungi of the genus *Penicillium* can cause infections in the lungs. Also there is a urinary infection of 12 years' duration which clinically resembled renal colic. *Penicillium citrinum* was repeatedly isolated from the urine in life and from kidney and bladder at autopsy. Species of *Penicillium* are often found in otomycosis.

* * *

• THE RELATIONSHIP between demand and nonfat calories is well established for thiamine.

* * *

• THE NUMBER of species of *Penicillium* is so large and the mycologic data on species pathogenic for man are so meager that it is not possible to include detailed descriptions of these fungi.

* * *

• THE DIAGNOSIS of *otomycosis* is suspected from the clinical appearance of the infection and is confirmed easily by microscopic examination. *Streptococcus* dermatitis of the ear may be confusing. Seborrheic dermatitis of the ear canal usually is associated with similar lesions elsewhere on the body. Impetigo contagiosa, furunculosis, contact dermatitis (nail polish), and allergic must be considered.

* * *

• ACUTE INFECTION, when accompanied by edema, should be treated conservatively to reduce the swelling and permit thorough cleansing of the ear canal. This may be accomplished by inserting into the canal a cotton wick saturated with Burow's solution.—J. F.

Hematologists in Disagreement as to Hemoglobin: Normal Values

Few well-informed physicians will deny that the practice of reporting hemoglobin in terms of percentage of any one of several widely divergent standards of normal is illogical and misleading. Some recognized hematologists have published reports advocating that as little as 13.8 gm. of hemoglobin per 100 cc. of blood be considered the level designated *100 per cent;* others would not use the term *100 per cent* for hemoglobin content less than 17.3 gm. per 100 cc.

In an effort to learn the present status of reporting hemoglobin values, questionnaires were mailed to 44 hospitals. The hospitals selected were large, teaching, university hospitals; large government general hospitals; large, outstanding hospitals in metropolitan areas; and three outstanding hospitals in smaller communities. All are known to have laboratories directed by thoroughly competent clinical pathologists.

Thirty-three replies were received. The reported basis for 100 per cent in men ranged from 14.5 to 17.2 grams with a mean of 15.3 grams. For women the basis ranged from 13.0 to 17.2 grams with a mean of 14.8 grams. Fifteen hospitals reported using the same basis for 100 per cent for both sexes.

From the foregoing it is apparent that Mrs. X, whose blood contained 13 grams of hemoglobin per 100 cc. would be reported by hospital A (13.0 gm.=100 per cent) as having hemoglobin value of 100 per cent and would be reported by hospital B (17.2 gm.=100 per cent) as having only 76 per cent. Conversely, Mrs. Y, whose blood contained 17.2 grams of hemoglobin per 100 cc. would be reported by hospital B as having 100 per cent hemoglobin and would be reported by hospital A as having 132 per cent hemoglobin.

MEN: The lower limit of "normal" range in men varied from 12.0 to 15.0 grams per 100 cc. and the upper limit from 15.0 to 18.0 grams per 100 cc. One hospital considers 15.0 grams hemoglobin per 100 cc. to be the lower limit of "normal," while another considers it to be the upper limit of "normal."

The narrowest "normal" range reported by any hospital was 15.0 to 16.0 grams. The broadest was 12.0 to 17.2 grams.

WOMEN: The lower limit of "normal" range in women varied from 12.0 to 14.5 grams and the upper limit from 14.5 to 17.2 grams. One hospital considers 14.5 grams per 100 cc. to be the lower limit of "normal," while another considers it to be the upper limit.

The narrowest "normal" range for women reported by any hospital was 13.9 to 14.5 grams and the broadest was 12.0 to 17.2 grams.—John J. Schaefer, M.D., Los Angeles: *California Medicine,* 80:32, January, 1954.

Maternal Mortality in Franklin County
A Five-Year Study

RICHARD L. MEILING, M. D., and ANTHONY RUPPERSBERG, Jr., M. D.

THE life expectancy of the population of the United States has been increased from 49 to 68 years during the first half of the twentieth century. Both the lay press and the medical profession have explained in great detail the phenomena of whole-blood and blood-derivative therapy, antibiotics, chemotherapy, and radioactive substances, as well as the improved medical and surgical techniques and hospital facilities which have each in its own right contributed so much toward this improved life expectancy record.

Deaths, many preventable, however, continue to occur in our modern society in one isolated and socially significant class—women in the active, child-bearing years—and as such we feel this problem must be of searching and continuous concern to the medical profession. The social problems, family and community-wide, arising from maternal deaths are so well known that they need not be elaborated upon in this presentation; suffice to mention the broken home, orphanage, foster parents, delinquency, and houses of correction as the most critical in our everyday life, which may be closely associated with a maternal death.

From January, 1937, through April, 1943, a project for studying maternal and fetal deaths in Ohio was sponsored by the Hospital Obstetric Society of Ohio. Data concerning maternal and fetal mortality and morbidity were collected from the 40 to 50 Ohio hospitals which cooperated in submitting data for the study.

The society had its inception in 1932, when a group of Cleveland obstetricians, dissatisfied with public criticism of obstetrical practice, formed a study group which later became the Cleveland Obstetric Society and included all Cleveland hospitals having a major obstetrical service.[1]

Statistics compiled from this study were published in 1938,[2] 1939,[3] and 1944.[4] They revealed astonishing facts and data but concerned only hospitalized cases classed as maternal deaths. However, the report also included cases delivered in the home, which were subsequently hospitalized and died in the puerperium.

Eventually the military demands of World War II caused the abandonment of this project and the activities of the Hospital Obstetric Society of Ohio.[4]

Bryant and Assali presented a ten-year (1937-1946) survey[5] in December, 1949. This survey carried 86 maternal deaths which occurred in Cincinnati (Ohio) General Hospital, with a final comparison of maternal mortality rates to those of hospitals elsewhere.

Submitted February 20, 1954.

The Authors

● A joint study for the Columbus Obstetric-Gynecologic Society by a committee consisting of the authors, with assistance as indicated in the text.

Your authors returned to Columbus after World War II impressed with personal observations of the maternal mortality problem as they had seen it in other cities and other lands. What was helping the mothers-to-be, the families, the communities and the medical profession in other areas impressed the authors with its potential value for the same group in Franklin County.

Columbus, Ohio, is a metropolitan community of approximately 500,000 population, with eleven hospitals of which eight have a maternity division (this includes a military hospital). In addition, three agencies operate maternity services, including delivery rooms, for unwed mothers. The obstetric cases arise from not only the metropolitan area but also from the county (Franklin), and the several counties adjacent to Franklin County.

In 1947, there were 9,282 live births reported in Columbus,[6] with 14 "puerperal deaths," or a "puerperal death rate" of 1.5 per thousand live births. The fact that this rate was higher than the maternal death rate for either Ohio or the United States for that year (Table 1) further convinced the authors that a local study to clarify the causes of maternal deaths would be worth while.

A thorough study of the original planning connected with a maternal mortality study in New York City (1930-1932)[7] proved exceedingly helpful to the authors. This magnificent report contained nuggets of information on various aspects, from philosophy to platform. Our planning fell into a similar pattern. Personal observations of the well established study (1931 to the present date) in Philadelphia, Pa., through the courtesy of Philip F. Williams,[8] provided inspiration for the local plan, with an ample forecast of trials which would be encountered.

THREEFOLD PURPOSE OF STUDY

The purpose of the study was threefold:

(1) Eventually to provide adequate maternal and intrauterine fetal (child) health;

(2) To offer an educational (training) pro-

gram for the medical profession, allied personnel (including early diagnosis of complications, and prompt, adequate consultation), and the lay public (newlyweds and expectant mothers); and

(3) To introduce and maintain standards of classification and nomenclature (recommended by World Health Organization and American Committee on Maternal Welfare) so that the Franklin County Maternal Mortality Study could be easily compared with the results and statistics of similar communities.

In order to obtain complete and accurate data, the full cooperation of several agencies and numerous individuals was obtained. The Columbus Health commissioner agreed to furnish the Maternal Mortality Study Committee with current data taken from the vital statistics records concerning maternal deaths occurring in Franklin County as the certificates were filed. The state health director and the state health department's Division of Maternal and Child Hygiene pledged complete support of the project from the state level.

TABLE 1.—MATERNAL DEATH RATE PER 1000 LIVE BIRTHS, UNITED STATES, OHIO, AND COLUMBUS, OHIO, 1930-1952

Year	United States	Ohio	Columbus
1930	6.7	5.8	7.1
1931	6.6	6.1	6.4
1932	6.3	5.8	7.6
1933	6.2	6.0	6.0
1934	5.9	6.0	4.2
1935	5.8	6.2	9.1
1936	5.7	4.9	5.6
1937	4.9	4.7	6.7
1938	4.4	3.9	4.0
1939	4.0	3.7	3.0
1940	3.8	3.2	3.1
1941	3.2	2.6	2.3
1942	2.6	2.1	2.0
1943	2.5	2.1	2.0
1944	2.3	1.9	2.4
1945	2.1	1.7	2.0
1946	1.6	1.1	0.8
1947	1.4	1.0	1.5
1948	1.2	0.8	**(1.6) 0.9
1949	0.9	0.6	(0.8) 0.8
1950	0.8	0.6	(0.8) 0.6
1951	0.7	0.5	(0.49) 0.5
1952	*	0.4	(0.68) 0.6

*Not Available

**Based on maternal deaths, included in Franklin County Maternal Mortality Study of deaths which occurred within Franklin County.

Source: United States from National Office of Vital Statistics; Ohio from Division of Vital Statistics, Ohio Department of Health; and Columbus from Columbus Health Department.

The first year, 1948, the authors undertook the development of the project of a maternal mortality study entirely on their own. As progress was made during the early months they proposed to their colleagues of the Columbus Obstetric-Gynecologic Society, at a regular meeting, that the society sponsor the study. By unanimous vote the society accepted sponsorship and financial support of the study, which was to be initiated and executed by a two-man committee, consisting of the authors. Thus, members of the society indicated their interest in the scientific study of medical problems, records, procedures and statistics related to obstetrical care in the community. Further, members informally agreed to support the project by furnishing detailed information to the committee upon the death of a maternity patient; they also agreed to encourage other members of the local medical profession to do likewise.

TABLE 2—MATERNAL* AND NONMATERNAL DEATHS, BY RESIDENCE, FRANKLIN COUNTY, OHIO, 1948-1952

Residence	Maternal Number	Maternal %	Nonmaternal Number	Nonmaternal %
Resident	46	75.4	15	71.4
Nonresident	15	24.6	6	28.6
Total	61	100.0	21	100.0

*Determined by vote of majority of members of Columbus Obstetric-Gynecologic Society.

In the meantime, certain policies were adopted by the Columbus Obstetric-Gynecologic Society for the operation of the maternal mortality study:

1. A standard form of questionnaire was devised to collect data for each maternal death occurring in Franklin County (Fig. 1). The form is a modification of the one used by the Children's Bureau of the U.S. Department of Labor, for the "Fifteen States Study," later adopted and used by the New York Academy of Medicine and the Philadelphia County Medical Society.[7,8] Presently, plans are being made to revise this questionnaire form to meet certain changes in terminology and coding used in the Sixth (most recent) Revision of the Manual containing the International Classification of Diseases, Injuries and Causes of Death, published by the World Health Organization.

2. The term *maternal death* was applied to include all deaths in women with either a nonviable or viable fetus, dying during pregnancy, labor and the puerperium from causes directly due to the pregnant state, such as abortion, ectopic pregnancy, placenta previa, etc., as well as associated causes such as heart disease, embolism, tuberculosis and other accidental complications of pregnancy.[9,10,11]

3. If death occurred in a woman in Franklin County, Ohio, within 12 months following the date of termination of the pregnancy, regardless of the length of gestation, the case was included in the study.[12]

4. At a regular meeting of the Obstetric-Gynecologic Society each year, every case was presented in full with all available details. An honest evaluation was made of each case presented. Concluding the discussion, each case was classified by simple majority vote to be either a nonmaternal or maternal death. Cases falling into the latter group were further classed as "Nonpreventable (NP)" or "Preventable (P)," with

TABLE 3—MATERNAL DEATHS, DELIVERED AND UNDELIVERED, BY PLACE OF DEATH AND DELIVERY, FRANKLIN COUNTY, OHIO, 1948-1952

Place of death	Place of delivery: Hospital Number	Hospital %	Home Number	Home %	Undelivered Number	Undelivered %	Total Number	Total %
Hospital	39	68.4	7	12.3	11	19.3	57	100.0
Home	4	100.0	—	0.0	—	0.0	4	100.0
Other	—	—	—	—	—	—	—	—
Total	41	70.5	7	11.5	11	18.0	61	100.0

the preventable group further determined as "Patient's responsibility (P_1)" or "Personnel responsibility (P_2)" for the death. ("Personnel" was defined as attending or consulting physician, resident or intern, nurse or other individual *administering* to the needs of the patient in contradistinction to the patient herself.)

5. All reporting was to be kept anonymous. At no time did the committee divulge the identity of any patient, physician or hospital concerned with the handling of the case.

6. Members of the committee received no financial remuneration for services rendered in connection with the study. They exerted no "police" action, nor did they possess legal authority in their work on the committee.

TABLE 4—MATERNAL DEATHS BY PARITY OF PATIENT, FRANKLIN COUNTY, OHIO, 1948-1952

Parity	Number	%
0 (primigravida)	17	27.9
I	12	19.7
II	13	21.3
III	5	8.2
IV	7	11.5
V	3	4.9
VI	2	3.3
VII	1	1.6
VIII	—	0.0
IX	1	1.6
Total	61	100.0

7. Toward the close of the five-year study, the committee saw fit to arrange cases in three groups on a basis of length of gestation at time of delivery of the fetus or at time of death of the mother if she had not delivered before death. This grouping is similar to that of the newer classification of "fetal deaths":[13] Group I (less than 20 completed weeks of gestation, when the maternal death occurred), Group II (20 completed weeks of gestation but less than 28), and Group III (gestation from 28 weeks through term). Further, a Group IV was provided for postabortal and postpartum deaths and for those which could not be classified in any of the three initial groups.

To date these policies still hold for the study.

It was necessary to obtain the cooperation of local hospital administrators, their house staffs and record room personnel. When the respective superintendents were thoroughly acquainted with the purpose and scope of the project, they usually pledged immediate support. At first, administrators and their staffs were skeptical of the committee's integrity, and, in one instance it was necessary for the committee to appeal directly to the medical staff in order to secure permission to obtain information from records of the hospital pertaining to the maternal mortality study; the superintendent finally agreed under subdued protest, to the unanimous vote of the hospital medical staff.

TABLE 5—MATERNAL DEATHS, DELIVERED AND UNDELIVERED, BY PERIOD OF GESTATION*, FRANKLIN COUNTY, OHIO, 1948-1952

Period of gestation	Fetus Delivered**	Fetus Not Delivered	Total Number	Total %
I Abortion, early	11	5	16	26.2
Under 6 weeks (ectopic)	4	1	5	
6-11 weeks	2	1	3	
12-19 weeks	5	3	8	
II Abortion, late	5	2	7	11.5
20-23 weeks	2	1	3	
24-27 weeks	3	1	4	
III Premature and Term	34	4	38	62.3
28-35 weeks (premature)	4	1	5	
36-40 weeks (term)	30	3	33	
Total	50	11	61	100.0

*At time of delivery of fetus or, if undelivered, at time of death of mother.

**All postpartum or postabortal deaths except one in period III (36-40 weeks) who died during delivery.

Members of the Columbus Academy of Medicine were apprised of the maternal mortality study through the pages of the Academy *Bulletin*, a monthly publication of distinctly high caliber and excellent repute. Without a doubt, this medium proved to be the most potent factor in educational training available to all physicians of Franklin County who practiced obstetrics. Complete reports were published annually, including a detailed outline of every case.[14-18] Throughout the five-year period of the study, efforts of the authors have been markedly advanced by the complete cooperation tendered by everyone involved.

A critical factor in this study was the attitude of those who were in possession of the facts desired by the investigator. Members of the medical

THE COLUMBUS OBSTETRIC-GYNECOLOGIC SOCIETY

COLUMBUS, OHIO

MATERNAL MORTALITY STUDY

1

1. Serial No. 2. Reg. No.

MOTHER (information from death certificate)

3. PLACE OF DEATH:

County City

Died at _____
(write word HOME or name of hospital)

4. Full name

Address

PERSONAL AND STATISTICAL DATA

5. Age	6. Color	7. Marital status

8. Occupation of deceased—Housewife, Other (specify)

9. Birthplace of deceased

10. Interval between birth and mother's death:

days hours mins.—Not reported, Not delivered (truly) (ectopic)

11. Number of children of this mother including this birth

(a) Born alive and now living

(b) Born alive and now dead

(c) Stillborn Not born

12. Date and hour of final hospital admission

17. INTERNATIONAL CODE CAUSE OF DEATH:

(a) Health Dept. (b) Study

18. Puerperal, N Preventable

Avoidable factor

Admitted as normal case, N

Pregnancy and labor responsible for death

(a) Directly (b) Indirectly (c) No connection

19. Postmortem deliveries (counted under 25 as "not delivered")—State here the result: Postmortem alive, Postmortem stillborn. Type of postmortem delivery

BABY (information from birth certificate)

20. PLACE OF BIRTH:

County City

Born at _____
(write word HOME or name of hospital)

MEDICAL CERTIFICATE OF DEATH

13. Date of death _____ (month, day, and year) , 19

14. I Hereby Certify, That I attended deceased from , 19 , to , 19 .

I last saw her alive on , 19 ;

death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows: | Date of onset

Other contributory causes of importance:

Name of operation Date of

Was there an autopsy?

Signed

Address

15. Autopsy—Examination, None

16. AUTOPSY REPORT:

21. If Stillborn—cause Before Labor During Labor

22. Premature mo. Full Term

23. Plural births—Twins, Triplets, Other (specify)

24. Legitimate, N.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

25. I HEREBY CERTIFY, that I attended the birth of this child who was born on 19 , at m.

Alive, Stillborn, Not delivered

Signed

Address

2

26. CONDITIONS IN MOTHER, NONE, NOT KNOWN

(a) Cardiac (e) Uterine displ.

(b) Chronic nephritis (f) Syphilis (specify)

(c) Tuberculosis (g) Others (specify)

(d) Tumors, etc.

27. PAST MEDICAL OR SURGICAL HISTORY, NONE, NOT KNOWN Specify

28. INTERCURRENT DISEASES, OPERATIONS, ABNORMALITIES, ETC. NONE, NOT REPORTED Specify

29. Treatment by physician, None. Specify and describe

30. COMPLICATIONS OF PREGNANCY, NONE, NR

31. Albuminuria, N. Began or first noted wk.

32. Convulsions, N. Began wk.

33. Oedema, N. Where and when began or noted

34. High blood pressure, N. Began or first noted wk.

Normal Lowest Highest

35. Prolonged headache, N. Began or first noted wk. Duration

36. Pernicious vomiting, N. Began wk. Duration

37. Bleeding during pregnancy, N. Began wk. Scanty, Moderate, Profuse, Once only, Recurred: daily, monthly, irregular

38. Treatment by physician, N. Specify

39. Abnormal conditions at onset of labor (not otherwise stated), N. Specify

40. PRENATAL CARE: Given by

41. Summary—Adequate, Inadequate, None, Excluded, NR

42. Visits

	Month of pregnancy											
	1	2	3	4	5	6	7	8	9			
									1	2	3	4
(a) Saw patient, N.												
(b) Urine exam., N.												
(c) Abdom. exam., N.												
(d) Blood pressure, N.												

43. Physical examination during pregnancy, N.

(a) Heart, N — Normal, Abnormal (specify)

(b) Lungs, N — Normal, Abnormal (specify)

(c) Pelvis, N — Normal, Abnormal (specify)

(d) X-ray of Pelvis, N

(e) Wassermann or Kahn, N — Negative, Positive, NR

Month of pregnancy taken

44. Abnormalities not observed by examining physician, N. Specify

45. Abnormalities affecting delivery and third stage, N

(a) Placenta—Adherent, Retained, Praevia, Premature separation,

(b) Hemorrhages—Antepartum, Intrapartum, Postpartum, Amount (estimate)

(c) Ruptured uterus—Spontaneous, Instrumental, During labor, During delivery, Before labor, Not known. Describe

(d) Others (specify)

(e) Treatment

46. ABORTION—Complete, Incomplete, Missed
Spontaneous, Induced (self), Questionable
Therapeu., N, Consultation, N, Indications for

47. ECTOPIC—Delivered, Not delivered (attempted)

48. NOT DELIVERED:

(a) In labor, N, No attempt at delivery

(b) Attempted delivery

1. Attempt to induce labor (a) Medical (b) Packing, etc.
2. Attempted operative delivery

49. CONSULTATION:

When complications first recognized

Before interference, After interference

DELIVERY DATA:

50. Attendant at actual delivery—Physician, Interne, Midwife, Student, Other, None, NR, Not delivered

51. Assisted, N (specify by whom)

52. Technique—(a) Vaginal examinations, N, Number
(b) Rectal examinations, N, Number
(c) Gloves, N (d) Shaved, N (e) Sterile goods, N (f) Preparation method and agents used

53. Presentation—Vertex (ROA) (ROP) (LOA) (LOP)
Transverse (specify)
Face (specify)
Other (specify)
Breech (specify)
Prolapsed (cord) (arm) (arms) (leg) (legs)

54. Membranes—Ruptured, Not ruptured, Excluded (a) Spontaneous, Artificial (b) Length of time before delivery hours

55. Labor—In labor, N, Excluded, Spontaneous, Induced (method used for induction)

Describe labor Duration hours mins.

56. Delivery—Spontaneous, Operative (specify) (indications)
Operative attempts (specify)

57. Third Stage—None, Normal, Abnormal (specify)
Management of third stage (if abnormal) and how long after delivery
Delivery before or after repairs

58. Tears—N (a) Episiotomy, N (b) Perineal, N, Degree
(c) Repaired, N (d) Cervical, N, NR
(e) Repaired, N

59. Amnesia, Analgesia, Anesthesia:
(Specify kind, amount and time given)
Anesthesia given by M.D. or R.N.

60. MATERNAL HISTORY: (Including present pregnancy)
Times pregnant Para Gravida

No.	Time between	Uterogestation (weeks)	Alive or stillborn (write the word)	Abnormalities that would affect pregnancy	Delivery (if operative, specify)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

61. Operation preceding death (only if other than shown under 56), N. Specify

(State how long after delivery or if not delivered how long before death.)

62. HOSPITAL CASE N: Delivered in hospital N

Planned, Emergency

63. Entered hospital—Before labor, During labor, After delivery days

64. Total hospital days Days in hospital of delivery

Days in hospital of death Days in other hospitals

Home days

(These refer only to hospitals connected with delivery and puerperium.)

65. If septic—(a) Developed in hospital, N

(b) Others in hospital at time, N

PRIMARY AND CONTRIBUTING CAUSES OF DEATH

140: Abortion with mention of infection (Gestation less than 28 weeks)

(a) With mention of pyelitis
(b) With mention of other infection
(c) Self-induced
(d) Criminal

141: Abortion without mention of infection (Gestation less than 28 weeks)

(a) With hemorrhage, trauma or shock and toxemia
(b) With hemorrhage, trauma or shock (no toxemia)
(c) With toxemia (no hemorrhage, trauma or shock)
(d) Without hemorrhage, trauma or shock or toxemia
(e) Self-induced
(f) Criminal

142: Ectopic gestation

(a) With mention of infection
(b) Without mention of infection

1. Symptoms began week. Describe
2. Interval between recognition of first symptom and operation
3. No operation
4. Sepsis

143: Hemorrhage of pregnancy (death bef. del.)

(a) Placenta Previa
(b) Premature Separation of Placenta
(c) Other and unspecified hemorrhage of pregnancy

1. When recognized
2. Specify method of control
3. Method of delivery

TREATMENT

TRANSFUSION (State definitely the time given, etc., in relation to hemorrhage, operative interference)

144: Toxemias of pregnancy (death bef. del.)

(a) Eclampsia of pregnancy
(b) Albuminuria and nephritis of pregnancy
(c) Acute yellow atrophy of liver (dur. preg.)
(d) Other toxemias of pregnancy

1. Pernicious vomiting (a) duration
(b) Operation, N. Refused by patient, N.

145: Other diseases and accidents of pregnancy (death bef. delivery)

146: Hemmorrhage of childbirth and puerperium (Gestation 28 weeks or over or unspecified)

(a) Placenta Previa
(b) Premature Separation of Placenta
(c) Other and unspecified hemorrhage with childbirth and puerperium

Inspection of placenta at delivery, N.

Method of delivery

Left patient after delivery, N. hrs.

Patient's condition satisfactory with dropping pulse, N.

TREATMENT

TRANSFUSION (State definitely time given, etc., in relation to hemorrhage, delivery, operative interference)

147: Infection during childbirth and puerperium (Gestation 28 weeks or over or unspecified)

(a) Puerperal pyelitis and pyelonephritis
(b) General or local puerperal infection (except pyelitis)
(c) Puerperal thrombophlebitis
(d) Puerperal embolism and sudden death

1. Operative delivery
2. Spontaneous
3. Symptoms appeared hours before delivery, hrs. after delivery
4. Intra-uterine manipulation, N. — Before symptoms, after symptoms
5. Blood culture, Smear, etc., N. — Negative Positive (give organism)
6. Embolus (specify)
   (a) Respiratory distress, N.
   (b) Cyanosis, N. (c) Cough, N.
   (d) Pain, N. (e) Other
7. TREATMENT
8. TRANSFUSION

148: Puerperal toxemias (excl. death bef. del.) (Gestation 28 weeks or over or unspecified)

(a) Puerperal eclampsia
(b) Puerperal albuminuria and nephritis
(c) Acute yellow atrophy of liver (puerperal)
(d) Other puerperal toxemias (see prenatal care)

1. Medical supervision before convulsions, N., duration
2. Condition when first seen
3. Symptoms began before death Convulsions, N., began hrs. before labor, during labor, hrs. after delivery
4. Cooperation of patient—good, poor, none (reason)

149: Other accidents and specified conditions of childbirth (Gestation 28 weeks or over or unspecified)

(a) Laceration, rupture, or other trauma of pelvic organs and tissues

(b) Other specified conditions of childbirth

1. Caesarean section:

(a) Specify type of operation

(b) Indications for

(c) Elective, Emergency

(d) Vaginal examination immediately before, N

(e) Membranes ruptured, N (hours)

(f) Patient in labor, N (hours). Type

(g) Temperature (specify)

(h) Operative interference before caesarean, N

2. Instrumental delivery and other operative procedures (enter the details under 56)

3. Ruptured uterus, N (a) Spontaneous, Instrumental (b) Treatment

4. Operative shock

150: Other and Unspecified Conditions of the puerperium

(a) Infection of breast during lactation
(b) Psychosis of the puerperium
(c) Other and unspecified conditions of childbirth and the puerperium

NON-PUERPERAL CAUSES OF DEATH *either Primary or Contributing*

Give number as coded in the Manual of the International List of Causes of Death with the cause written after (as 121-Appendicitis)

A + Primary:

B + Contributory:

Informant

Agent

Date of Visit

Summary of case:

Fig. 1. Standard questionnaire form, Maternal Mortality Study, Columbus Obstetric-Gynecologic Society.

profession in Franklin County have continuously met the challenge and assisted in the maintenance of this project by contributing detailed information in connection with all cases of maternal deaths.

The collection of material and information for the study continued. In 1949 and 1950, Drs. James W. Norris and Leonard B. Greentree were appointed to join Dr. Ruppersberg on the committee, while Dr. Meiling was serving as Assistant to the Secretary of Defense for Medical and Health Affairs. With the return of Dr. Meiling to Columbus in July, 1951, he again became an active member of the committee with Dr. Ruppersberg. Drs. Olan P. Burt and Joseph M. Gallen served with the committee in 1951 and 1952.

Meanwhile, additional efforts were continued to inform and educate physicians of the community with the results and critical analysis offered by the maternal mortality study. In an effort to arouse state-wide interest, a preliminary summary of the study for a four-year period was published in *Ohio's Health*.[19] In addition to periodic reports in the Columbus Academy of Medicine *Bulletin* (which reached 700 physicians of Franklin County), the local press carried a feature story concerning the study, particularly designed to appeal to the lay public.[20] The *Bulletin* continues to be the principal and outstanding medium for the transmission of the study's facts and features of educational value to the physician.[14-18]

Presently, the Franklin County, Ohio, Maternal Mortality Study is embarking upon its seventh successive year, as material is being collected for the 1954 study. It is anticipated that a similar study concerning fetal loss will soon be forthcoming, to complete the scope of the program for the reduction of maternal and fetal wastage.

PRELIMINARY STUDY

As a preliminary study, the maternal mortality rates (per 1,000 live births) were compared for specified years at a national level,[21] at a state level (Ohio),[22] and at a city level (Columbus, Ohio),[6] 1930 to 1945, inclusive. Table 1 reveals a current and gradual decline in the national and state rates, but also shows a much higher rate for Columbus for 1932, 1935 and 1937, after which the rate for Columbus followed a decline similar to both the national and state rates. Graphically this feature is demonstrated in figure 2. This 15-year period was selected for study especially because maternal deaths were computed according to place of *death* (recorded deaths), whereas from 1946 to the present date the deaths were assigned according to place of *residence* of the mother.

It was gratifying to realize that statistics available from the Columbus Health Department reflected a progressive decline in the local maternal mortality rate from 1930 through 1952.[6] There was a relative drop in the maternal mortality rate due to a change in the system of classification.[10] However, this is slightly more significant when the rate is compared with the Columbus birth rate[6] on a similar basis (Fig. 3). This graph reveals a declining maternal mortality rate, even in the presence of a rising birth rate.

Although the maternal mortality rate followed a progressive decline for the City of Columbus, it failed to reflect accurately the picture in numbers of mothers who died within the city limits. Without pointing any criticism toward the Columbus Health Department and its vital statistics section, it was customary to cite only resident deaths which occurred in Columbus. Notwithstanding the fact that nonresident mothers received medical care and hospitalization in metropolitan Columbus, nonresident mothers who died in the city were not carried in the published rates until the advent of this maternal mortality study. In fact, 24.6 per cent of the 61 maternal deaths were nonresident cases (Table 2). The comparative true rates are shown in figure 4 and reflect a welcomed drop in the "over-all" rate provided by this study.[14-18] Both the *state* and *county* (including the city) maternal mortality rates are approximately the same for the year 1952. The national rate for 1952 is not available at the time of this publication, but for 1951

TABLE 6—MATERNAL DEATHS, BY INTERVAL BETWEEN BIRTH OF FETUS AND DEATH OF MOTHER AND BY CAUSE OF DEATH, FRANKLIN COUNTY, OHIO, 1948-1952

Interval between birth of fetus and death of mother	Cause of death				Total	
	Hemorrhage	Infection	Toxemia	Other	Number	%
None (undelivered)	1	—	4	6	11	18.0
Under 1 hour	2	—	—	1	3	
1-12 hours	4	2	3	2	11	31.1
13-23 hours	1	—	2	2	5	
1- 6 days	3	3	2	7	15	24.6
7-27 days	1	7	—	4	12	19.7
1- 2 months	—	1	1	1	3	
3- 5 months	—	1	—	—	1	6.6
6-11 months	—	—	—	—	—	
Total	12	14	12	23	61	100.0

(Table 1) it was approximately the same as the Ohio, Columbus and Franklin County rates.

FIVE-YEAR STUDY

This report represents the first comprehensive effort to evaluate, over a five-year period, the problem of maternal mortality in a metropolitan county of Ohio using international standards of nomenclature. The report contains a wealth of information for those who search for it. Some conclusions are so self-evident that they need not be recorded.

TABLE 7—MATERNAL DEATHS BY PERIOD OF GESTATION* AND TYPE OF DELIVERY, FRANKLIN COUNTY, OHIO, 1948-1952

Period of gestation	Type of delivery			
	None (undelivered)	Spontaneous	Operative	Total
I Under 20 weeks	5	2	9	16
II 20-27 weeks	2	4	1	7
III 28-35 weeks	1	1	3	5
III 36-40 weeks	3	10	20**	33
Total	11	17	33	61
Per cent	18.0	27.9	54.1	100.0

*At time of delivery of fetus or, if undelivered, at time of death of mother.
**Includes one death during delivery.

From the Five-Year Maternal Mortality Study in Franklin County, Ohio, certain interesting facts have been gleaned. The total cases studied in this period of time were 82, of which 61 (74.4 per cent) were classified as *maternal deaths*. The 61 maternal deaths for the five-year period occurred among 68,951 live births for a corrected maternal mortality rate of 0.884 per thousand.

Of the 61 deaths, 57 (or 93.4 per cent) died in hospitals (Table 3). It is curious to note that of the 61 patients, 70.5 per cent were delivered in a hospital, 18 per cent were undelivered at time of death, and 11.5 per cent were delivered at home. But among the mothers whose death occurred at home, none was delivered in her home and none died undelivered.

Table 4 shows the parity of the maternal deaths. The greatest portion of the 61 maternal deaths (27.9 per cent) were primigravidous patients, while the next most frequent parity was "Para II" with 21.3 per cent of the deaths.

TABLE 8—MATERNAL DEATHS WITH OPERATIVE DELIVERIES, BY TYPE OF OPERATIVE DELIVERY, FRANKLIN COUNTY, OHIO, 1948-1952

Type of Delivery	Number
Low forceps	6
Axis traction forceps	1
Mid forceps	3
High forceps	—
Cesarean section*	13
Hysterectomy, total	—
Hysterectomy, subtotal	—
Hysterotomy	1
Laparotomy**	5
Breech extraction	—
Version and Extraction	—
Accouchment Force	—
D. & C. or miscellaneous intervention in criminal abortion	4
Total	33

*Includes 1 Porro type.
**3 Ectopic and 2 Ruptured uterus.

One patient was a "Para VII" and one a "Para IX," the highest parity.

As shown in Table 5, for 50 of the 61 maternal deaths. or 82.0 per cent, the fetus *was delivered.* For all of these except one, the death occurred in the postpartum or postabortal period. In 62.3 per cent of the maternal deaths, the period of

TABLE 9—ANALYSIS OF CESAREAN SECTIONS, BY TYPE, INDICATION AND CAUSE OF MATERNAL DEATH, FRANKLIN COUNTY, OHIO, 1948-1952

Type	Indication (if obtainable)	Cause of death
1. Porro (subtotal hysterectomy)	Previous cervical amputation, ruptured amnion.	Intrauterine infection, shock, anoxia.
2. Classical	Cephalopelvic disproportion.	Decerebrate state due to anoxia, respiratory paralysis due to spinal anesthesia.
3. Classical	Abruptio placenta.	Cardiac failure, wound abscess.
4. Classical	Eclampsia, moribund, attempt to extract (questionably) live fetus.	Toxemia, eclampsia.
5. Elective low cervical	Repeat Cesarean Section, previous Cesarean Section for disproportion with pulmonary emboli following the section.	Pulmonary embolism, multiple, thrombosis of iliac veins.
6. Classical	Diabetes, toxemia, temporarily controlled.	Diabetes, cerebral edema, pulmonary edema.
7. Classical	Repeat Cesarean Section.	Intestinal obstruction, paralytic ileus.
8. Low cervical	Previous myomectomy and suspension, moderate pelvic contraction.	Undetermined tetany (clinical), myocardial dilatation, pulmonary congestion, hydronephrosis.
9. Classical	Diabetes, pre-eclampsia.	Shock, cardiac failure during operation.
10. Classical	Abruptio placenta.	Circular collapse, abruptio placenta, pre-eclampsia.
11. Low cervical, ligation and myomectomy	Toxemia (?), failure of medical induction of labor.	Hepatitis, toxemia of pregnancy, pulmonary atelectasis.
12. Low cervical	Pre-eclampsia, elderly primipara.	Eclampsia, membranous glomerulitis, necrosis of liver, and myocardium, cerebral edema.
13. Classical, ligation and appendectomy	Dead Fetus (?) Tubal ligation (?)	Lower nephronephrosis (Transfusion reaction).

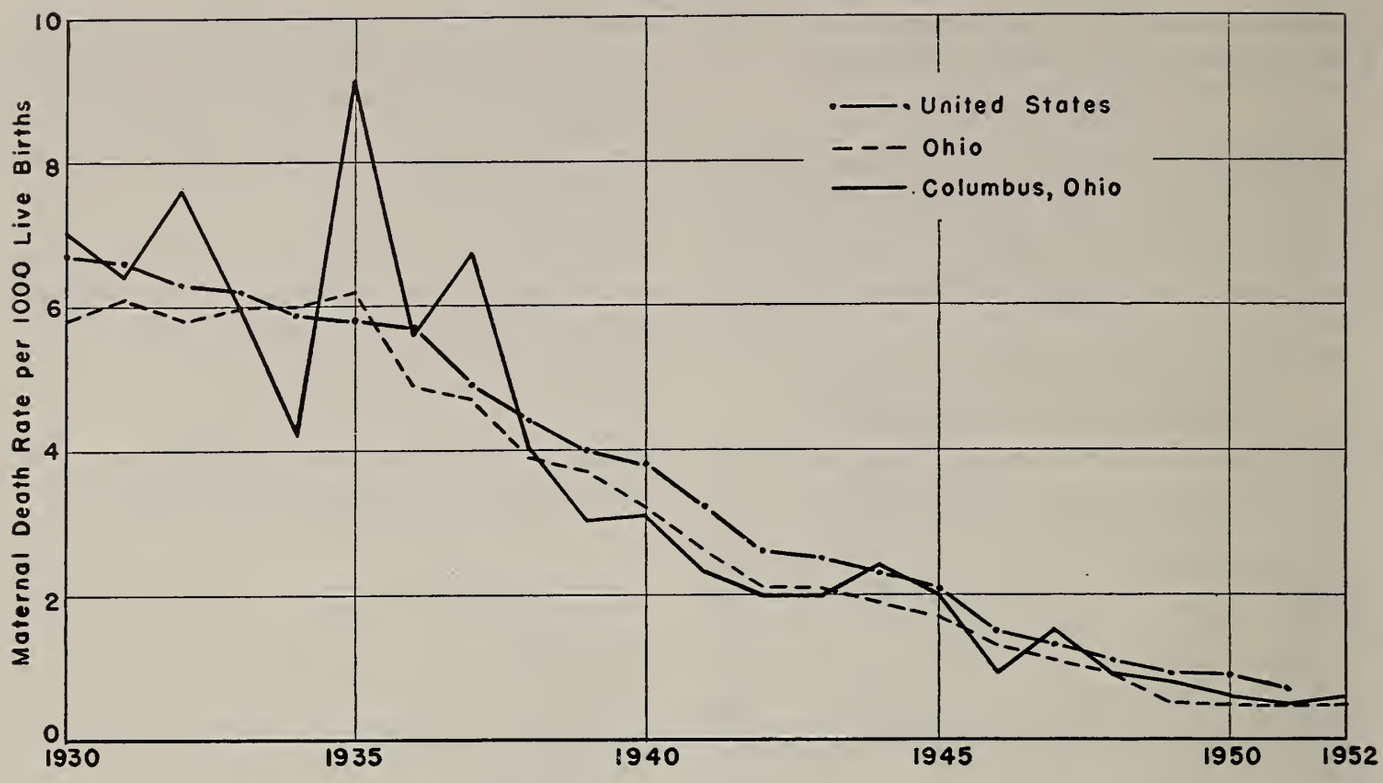


Fig. 2. Maternal Death Rate per 1000 Live Births, United States, Ohio, and Columbus, Ohio, 1930-1952.

gestation of the fetus at time of delivery or at time of death of the mother was Group III (28 weeks through term). However, 26.2 per cent of the mothers were in the early period of gestation (less than 20 weeks) at the time of death. In this same group there were four ectopic pregnancies (of less than six weeks gestation).

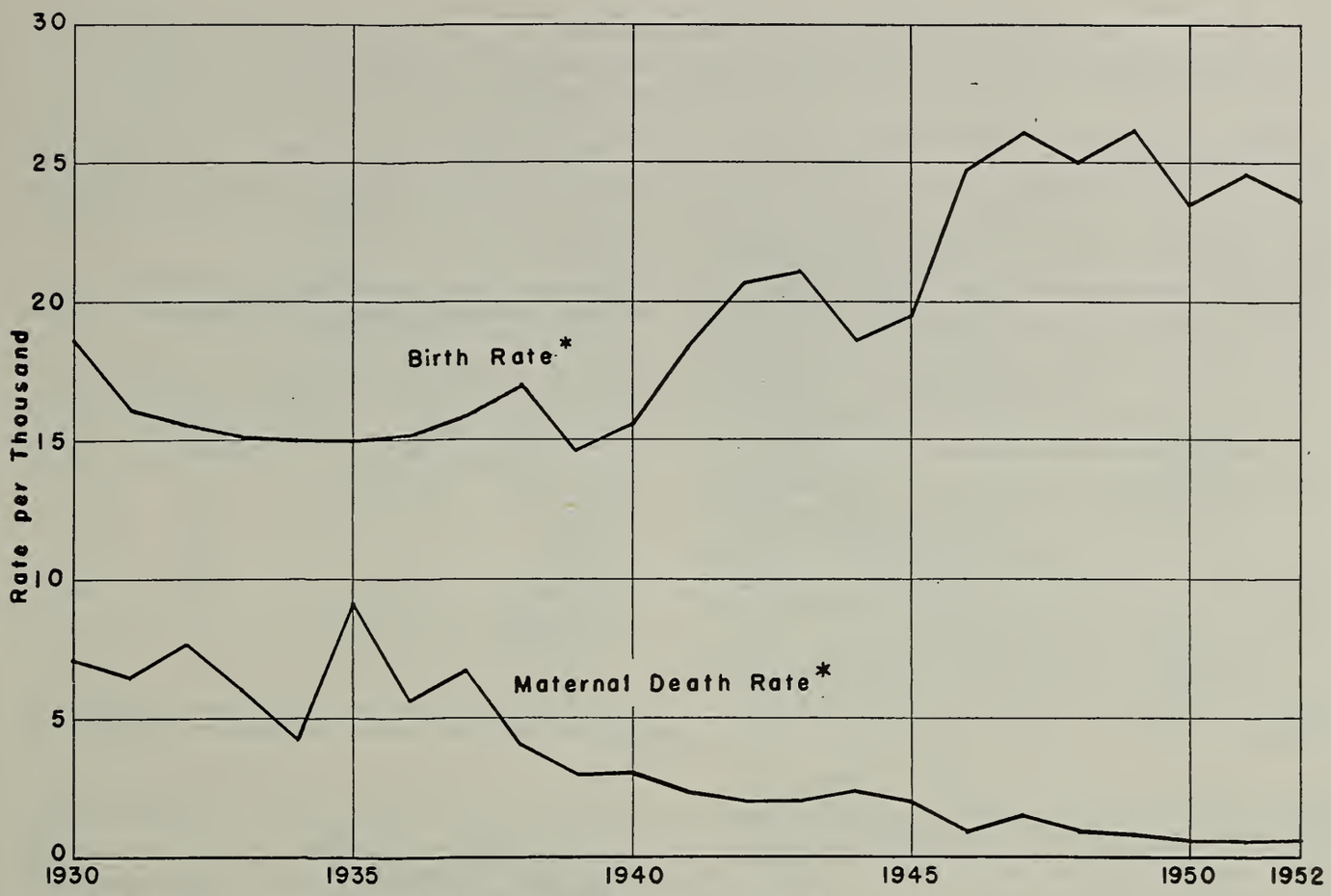
The length of time which the mother lived after delivery, together with the cause of her death, is presented in Table 6. Thirty-one per cent of the deaths occurred within 24 hours after delivery! If only those who were delivered before death are considered, the proportion is even greater—38.0 per cent occurring in the first 24 hours. The "three horsemen (hemorrhage, infection, toxemia) who carry death to the mother" accounted for 14 of these 19 deaths following so soon after delivery. Seven were due to hemorrhage, two to infection, and five to toxemia. Another 24.6 per cent died before the end of the first week, while 18 per cent had died undelivered. Nearly *three-fourths* of the maternal deaths occurred either before delivery or within the first week postpartum! When only the 50 mothers who *were delivered* were considered, it was found that two-thirds of these were dead by the end of the first week postpartum.

In agreement with the findings in the Minnesota[11] and Illinois[24] reports, surgical and operative intervention also placed a significant mark upon our series of 61 maternal deaths. Excluding those patients who died undelivered, 66.0 per cent of those who died were subjected to an operative type of delivery (Table 7). Laparotomy performed for ectopic pregnancy is included as an operative delivery in this report. The predominant type of surgical procedure (39.4 per cent of the 33 operative deliveries) proved to be cesarean section (Table 8). An analysis of these 13 cesarean sections with indication and cause of death is provided in Table 9. Of the 13 cesarean operations, 8 (or 61.5 per cent) were of the "classical" type; 2 of the 13 had an elective additional procedure performed, namely (1) tubal ligation and myomectomy, and (2) tubal ligation and appendectomy.

Further analysis of "Other Operations" listed in Table 8, by type, indication and cause of death is shown in Table 10. It is noteworthy that there are two cases of spontaneous rupture of the uterus at term, during labor. Neither of these multiparous patients had had any previous surgery performed upon the uterus. Three cases of ruptured ectopic pregnancy are also among this group.

A summary of the primary causes of the 61 maternal deaths is given in Table 11. Hemorrhage, infection and toxemia combined, accounted for 62.3 per cent of the deaths. For each of these causes the incidence was approximately the same. Among the 12 deaths due to infection there was not a single one due to puerperal fever. This group includes various infections ranging from tetanus and B. Welchii to far advanced tuberculosis. Undoubtedly, the absence of puerperal infection per se in these statistics is a result of the tremendous advances in chemotherapy and antibiotics in the past ten years. There were eight deaths due to cardiac conditions and five due to embolism.

For further study, the cause of death in three (customary) specified categories, in each sepa-



*Birth rate per 1000 population. Maternal death rate per 1000 live births.

Fig. 3. Birth Rate per 1000 Population and Maternal Death Rate per 1000 Live Births, Columbus, Ohio, 1930-1952.

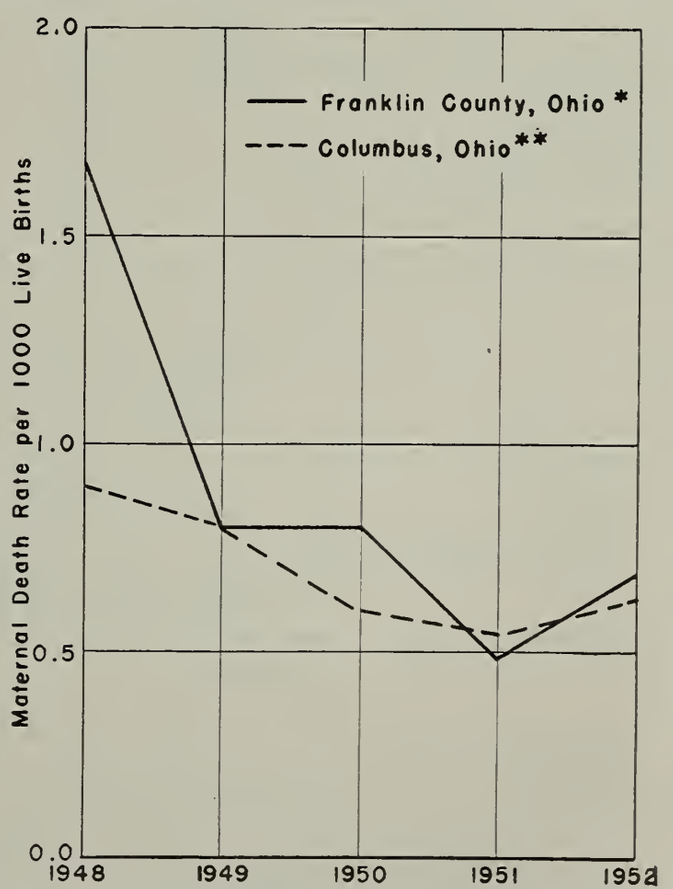
rate year, is tabulated for the maternal cases in Table 12. Of the 12 cases of toxemia, ten were listed as eclampsia, whereas two were pre-eclampsia. Four ectopic pregnancies are listed under "hemorrhage," one of which was not subjected to surgery.

Also for further study, the "Other Causes" of death for maternal cases are tabulated in Table 13. Five patients died of pulmonary embolism, and eight died of a primary cardiac cause.

An analysis of the 21 *nonmaternal* cases with period of gestation and cause of death is tabulated in Table 14. In most instances, the cause of death as listed gives a good clue to the classification into a nonmaternal category. Two of the nonmaternal cases were *homicides*. All nonmaternal cases were studied and presented in the usual thorough manner before the society voted a classification of "nonmaternal."

Table 15 shows the fate of the fetus according to period of gestation. For 42.6 per cent of the 61 maternal deaths the fetus was live born, while for 18.0 per cent the fetus was undelivered. Eliminating the undelivered and previable premature fetus, the proportion of live born fetuses delivered by these mothers was actually 73.5 per cent. The ultimate fate of the live born child in the neonatal period (from time of birth to four weeks of age) was not included in our statistics.

The age of the mother at time of death is given in Table 16. The majority of the maternal deaths were among women between 25 and 34 years of



*Based on maternal deaths, included in Franklin County Maternal Mortality Study of deaths which occurred in Franklin County.
**Based on maternal deaths, resident of Columbus, and recorded by the Columbus Health Department.

Fig. 4. Maternal Death Rate per 1000 Live Births, Franklin County, Ohio (Maternal Mortality Study) and Columbus, Ohio, 1948-1952.

age with an average age of 29.5 years. Four were 40 to 44 years of age and five were 15 to 19 years of age.

A final comparison of statistics for the Five-Year Maternal Mortality Study, Franklin County, Ohio, by year is presented in Table 17. Maternal deaths occurred predominately among white women (80.4 per cent). The number of autopsies obtained in maternal mortality cases (Table 17) reflects a rather poor average for the five years, namely 55.7 per cent, compared to 44.3 per cent not performed. In 1951, for example, there were two autopsies (or 28.6 per cent) performed out of seven maternal deaths; this is the lowest percentage of the total of any year. Yet after close analysis of the cases in 1951, the five maternal cases upon which autopsy permission was refused had been subjected to laparotomy (including cesarean section) prior to death (see Tables 12 and 13). Undoubtedly, persuasion of the family by the attending physician was omitted and permission for autopsy was either not requested or refused.

In comparison, the Cincinnati[5] report for a period of 10 years bemoans a poor autopsy rate of only 36 per cent, in a general hospital; the Cincinnati authors believe the reason for the low rate may be (1) due to relatives of the class of patient with which they deal, or (2) related to a rumor that undertakers discourage the family from granting permission for autopsy. We have no figures to support either contention.

The Columbus Obstetric-Gynecologic Society, over the five-year period, voted 13 of the 61 maternal deaths (21.3 per cent) to be non-preventable (Table 18). However, of the 48 preventable maternal deaths, the society assessed responsibility for 10 deaths to the patient (P_1), whereas 38 were classed as P_2, the responsibility of personnel (including the physician, intern, resident, nurses, etc.). In terms of statistics, 79.2 per cent of the preventable maternal deaths were the responsibility of personnel. This astonishing majority figure corresponds closely to statistics reported in large maternal studies previously published.[11]

Causes of maternal death in Franklin County Maternal Mortality Study are compared to those statistics from other studies conducted elsewhere, in Table 19. In four reports, percentages of total maternal deaths show a great similarity for the "three horsemen which carry death to the mother," i.e., hemorrhage, infection, and toxemia. The Franklin County Study reveals a higher incidence of infection as a primary cause of death which is possibly due to the committee's inclusion of additional infectious processes.

TABLE 11—MATERNAL DEATHS BY PRIMARY CAUSE OF DEATH, FRANKLIN COUNTY, OHIO, 1948-1952

Cause of Death	Number	%
Hemorrhage	12	19.7
Infection	14	22.9
Toxemia	12	19.7
Cardiac	8	13.1
Embolism	5	8.2
Anesthesia	2	3.3
Hyperemesis	2	3.3
All other*	6	9.8
Total	61	100.0

*Includes one case of each of the following: diabetes, pneumonia, intestinal obstruction, nephronephrosis, tetany, and anemia.

PRENATAL CARE

The importance of prenatal care in the promotion of maternal and fetal health needs no reiteration in this report. However, either the

TABLE 10—ANALYSIS OF OTHER ABDOMINAL OPERATIONS BY TYPE, INDICATION, AND CAUSE OF MATERNAL DEATH, FRANKLIN COUNTY, OHIO, 1948-1952

Type	Indication (if obtainable)	Cause of death
1. Laparotomy, salpingectomy.	Ruptured ectopic pregnancy.	Pulmonary edema, cerebral anoxia, ruptured ectopic pregnancy, hemoperitoneum.
2. Laparotomy, salpingectomy, suspension of uterus.	Ruptured oviduct pregnancy.	Right ectopic pregnancy, acute glomerulonephritis.
3. Hysterotomy, tubal ligation.	Pregnancy 4 months, Pulmonary tuberculosis: far advanced, malnutrition. (Consultation)	Respiratory failure, pulmonary tuberculosis with collapse of lung.
4. Laparotomy, hysterectomy, subtotal.	Ruptured uterus, massive intra-abdominal hemorrhage.	Exsanguination, massive intra-abdominal hemorrhage, ruptured uterus, prolonged labor, diabetes mellitus (severe), fetus extra-uterine (dead) large. Term.
5. Laparotomy, hysterectomy, subtotal.	Ruptured uterus, sudden profound shock.	Spontaneous rupture of pregnant uterus at term during labor, etiology undetermined, (extra-uterine fetus).
6. Laparotomy, salpingectomy.	Ruptured ectopic pregnancy.	Pulmonary edema, heart failure, intra-abdominal bleeding, ruptured tubal pregnancy.
*7. Laparotomy, tubal ligation (postpartum).	Voluntary bilateral uterine tubal ligation. (Consultation)	Pulmonary embolism, following surgery, of puerperium.
*8. a) D & C, bilateral salpingectomy, and appendectomy.	a) Abortion, late, complete (?)	Peritonitis, pelvic abscess. Perforation of cecum, thrombophlebitis right iliac vein, pericarditis.
b) (2 months later) colpotomy, drainage.	b) Pelvic abscess	

*Not an operative delivery and therefore, not included in Table 7, Maternal Deaths by Period of Gestation and Type of Delivery.

TABLE 12

MATERNAL DEATHS DUE TO HEMORRHAGE, INFECTION AND TOXEMIA, BY SPECIFIC CAUSE AND YEAR OF DEATH, FRANKLIN COUNTY, OHIO, 1948-1952

Year	Hemorrhage	Infection	Toxemia
1948 (13 deaths)	1. Ruptured ectopic pregnancy (OP) 2. Ruptured ectopic pregnancy (OP) 3. Hemorrhage (and sepsis), incomplete abortion (Induced). 4. Incomplete abortion, (Induced), hemorrhage.	1. Tetanus (abortion, induced) 2. Tuberculosis meningitis 3. Shock, amnionitis, sepsis (6 months pregnant, previous cervical amputation) 4. Far advanced pulmonary tuberculosis, malnutrition (hysterotomy at 4 months) 5. Peritonitis, paralytic ileus. 6. Postpartum fever, (undulant fever plus pancarditis).	1. Eclampsia (6½ months) 2. Eclampsia, renal and respiratory failure, (7½ months). 3. Eclampsia (8 months).
1949 (6 deaths)	5. Postpartum hemorrhage, shock, laryngospasm.	7. Peritonitis (post-appendectomy) 8. Wound abscess, peritonitis (post Cesarean Section) 9. Postpartum Infection? Congestive heart failure?	4. Eclampsia (7 months) 5. Eclampsia (39 weeks)
1950 (7 deaths)	6. Exsanguination, postpartum inertia, retained secundines.	10. Peritonitis, (pin-point) perforation of cecum; positive culture of B. Welchii. 11. Acute caseopneumonic tuberculosis and postpartum hemorrhage. 12. Acute upper left lobe pneumonia (Tuberculosis)	6. Eclampsia (term). 7. Eclampsia (32 weeks). 8. Pre-eclampsia, diabetes cardiac arrest (Cesarean Section, 38 weeks).
1951 (6 deaths)	7. Spontaneous rupture of uterus during labor at term, (OP). 8. Exsanguination, massive internal hemorrhage, spontaneous rupture of uterus during labor at term, large fetus (OP). 9. Shock, abruptio placenta, circulatory collapse, mild pre-eclampsia (Cesarean Section).	13. Pulmonary edema, renal abscess pyelonephritis, incomplete abortion (2 months).	9. Eclampsia (term); Pulmonary edema. 10. Eclampsia, aspiration pneumonia (Cesarean Section, term).
1952 (6 deaths)	10. Ruptured ectopic pregnancy (no OP). 11. Ruptured ectopic pregnancy, heart failure (OP). 12. Hemorrhage (internal), unknown cause, 2 weeks postpartum (no OP).	14. Incomplete abortion (Induced), Tetanus.	11. Pre-eclampsia, hypertension, cerebral hemorrhage (39 weeks). 12. Eclampsia (term), (cesarean section).

TABLE 13

MATERNAL DEATHS DUE TO OTHER CAUSES BY SPECIFIC CAUSE AND YEAR OF DEATH, FRANKLIN COUNTY, OHIO, 1948-1952

Year	Cause of Death
1948 (9 deaths)	1. Hyperemesis gravidarum, pulmonary edema; adrenal cortical adenoma. 2. Acute congestive heart failure; malignant nephrosclerosis. 3. Cardiac failure; pheochromocytoma. 4. Pneumonia; thrombosis of pelvic vessels. 5. Respiratory paralysis (spinal anesthesis) pulmonary congestion. 6. Rheumatic heart disease (grade 2); myocardial failure. 7. Subacute bacterial endocarditis; peripheral vascular failure. 8. Rheumatic heart disease; mitral stenosis. 9. Pulmonary embolism; shock.
1949 (5 deaths)	1. Rheumatic heart disease; pulmonary congestion. 2. Pulmonary embolism. 3. Myocardial decompensation; nephritis; hypertension. 4. Diabetes mellitus. 5. Intestinal obstruction; paralytic ileus.
1950 (4 deaths)	1. Respiratory paralysis; hyperemesis gravidarum. 2. Rheumatic heart disease. 3. Tetany (clinical); myocardial dilatation; pulmonary congestion. 4. Aspiration pneumonia; acute pulmonary edema; difficult delivery.
1951 (1 death)	1. Pulmonary embolism; (surgery, parturition).
1952 (4 deaths)	1. Pulmonary embolism; pelvic compression (fibroids, pregnant). 2. Pulmonary embolism; thrombophlebitis. 3. Anemia (clinical); multiple lacerations of cervix; laceration lower segment, bilateral pulmonary congestion; edema lower extremities. 4. Lower nephronephrosis.

lack of adequate prenatal care or its entire omission forms an important link in the chain of events which lead to maternal death and fetal death. The questionnaire form adopted for the Franklin County Maternal Mortality Study (Fig. 1) provides a definite set of questions (items 26 to 44 inclusive) which, when answered, furnish definite facts upon which a conclusion may be based concerning the adequacy of prenatal attendance received by the patient.

From a study of Table 20, it is seen that in the 61 *maternal deaths* adequate prenatal care was provided for 47.5 per cent of the patients, whereas 19.7 per cent received inadequate care, and 11.5 per cent had no prenatal care whatsoever. The status of prenatal care was not known for the remaining 21.3 per cent of the cases; included in this figure were cases in which the patient failed to appear for prenatal care, and cases where the attending physician kept no record of prenatal visits and was unable to supply the desired information.

Bryant and Assali[5] in the Cincinnati study found no *adequate* prenatal care in 83 cases, but reported "*No* prenatal care" in 67 of the cases, "Irregular prenatal care" in 6, while prenatal care was "Undetermined" in the remaining 13 cases.

In comparison, the Minnesota Mortality Study[11] reported that of 68 cases, *adequate* prenatal care was administered in 22.1 per cent of the cases, *faulty* care was received by 69.2 per cent of the patients, and the remaining 8.8 per cent of the cases received *no* prenatal care.

Currently, a uniform set of minimum requirements for adequate prenatal care is in the process of completion; this is similar to those published in Minnesota[11] and Kansas.[23]

SUMMARY

1. A continuous, annual maternal mortality study is being conducted in Franklin County (Columbus), Ohio, by the Columbus Obstetric-Gynecologic Society. A general summary of the planning, progress and statistical findings of the study for five years (1948 through 1952) has been presented.

2. Sixty-one maternal deaths occurred in the five-year period among 68,951 live births, for an uncorrected maternal mortality rate of 0.884.

3. Of the 61 cases, 93.4 per cent of the patients died in hospitals. In parity, the greatest proportion were primigravidous, while the next most prominent parity was "Para II"; "Para I" was next most frequent.

4. Surgical and operative intervention re-echo the hazards of unwarranted meddling. In those cases in which the patients died during or after delivery, 66.0 per cent were subjected to an operative type of delivery, of which 39.4 per cent were cesarean sections. Of the cesarean operations 61.5 per cent were of the classical type. As previously stated, these findings compare favorably with those published by the Minnesota Maternal Mor-

TABLE 14—NONMATERNAL DEATHS BY PERIOD OF GESTATION AND CAUSE OF DEATH, FRANKLIN COUNTY, OHIO, 1948-1952

	Period of gestation	Cause of death
1.	(Postabortal)	Acute hepatitis, cause undetermined; follicular cysts of ovaries, pulmonary congestion.
2.	Undelivered—less than 20 weeks gestation	Cerebral-vascular hemorrhage, ruptured aneurism of arteries connecting Circle of Willis.
3.	(Postpartum)	Acute ulcerative ileitis, purulent peritonitis.
4.	(Postpartum)	Post pneumonectomy, broncho-cutaneous fistula, cor pulmonale, congestive heart failure.
5.	(Postabortal)	Post lobectomy, acute cardiac dilatation, pulmonary edema, rheumatic heart disease with stenosis.
6.	(Postpartum, 5 months)	Post-operative nasal surgery, chronic mastoiditis, acute enteritis, chronic gastritis.
7.	(Postpartum, 6 months)	Chronic ulcerative colitis.
8.	(Postpartum, 7 months)	Azotemia, lower nephronephrosis, prolonged hemorrhage, shock, (Pneumonectomy).
9.	(Postpartum, 8 months)	Second and Third degree burns of skin, back, arms, buttock; alcohol and barbiturates.
10.	Undelivered—20-27 weeks gestation	Carcinoma (Boeck's sarcoid) metastasis to lungs, primary site undetermined.
11.	(Postpartum, 8 months)	Recent myomectomy, ligation, appendectomy and conization; cerebral edema, myocarditis.
12.	(Postpartum, 6 months)	Meningioma of left occipital lobe.
13.	(Postpartum, 2 weeks)	Alleged homicide: Manual strangulation, fracture of hyoid bone, massive hemorrhage (coroner's report).
14.	Undelivered—28-40 weeks gestation	Hemorrhage infarction of stomach with spontaneous perforation; pulmonary atelectasis, bilateral (coroner's report).
15.	(Postpartum, 5 months)	Acute rheumatic myocarditis, empyema, septicemia. P.I.D.
16.	Undelivered—20-27 weeks gestation	Cerebral contusion and laceration, (accidental).
17.	(Postpartum, 3 months)	Peritonitis; acute perforation of colon; ulcerative colitis, acute.
18.	(Postpartum, 4 days)	Pulmonary edema, subarachnoid hemorrhage, ruptured cerebral aneurism.
19.	(Postpartum, 2 months)	Poliomyelitis (coroner's report).
20.	(Postpartum, 8 months)	Alleged homicide (coroner's report).
21.	(Postpartum, 18 days)	Intestinal obstruction due to malrotation, congenital; gangrene of intestine.

tality Committee[11] and by Newberger in his report on maternal mortality in Downstate Illinois.[24]

5. Hemorrhage, infection, and toxemia accounted for 62.3 per cent of the maternal deaths included in this study.

6. "Childbed," or puerperal fever, was not a primary cause of death for any of the 61 maternal deaths. "Infection" as a cause of maternal death here includes tetanus, gas gangrene, tuberculosis, undulent fever, etc., and accounts for 12 of the cases.

7. Cardiac disease accounts for eight of the 61 maternal deaths, while another five died of

TABLE 15—MATERNAL DEATHS BY PERIOD OF GESTATION* AND FATE OF THE FETUS, FRANKLIN COUNTY, OHIO, 1948-1952

Period of gestation	Fate of Fetus			
	Not born	Born dead	Born alive	Total
I Under 20 weeks	5	11	—	16
II 20-27 weeks	2	4	1	7
III 28-35 weeks	1	3	1	5
III 36-40 weeks	3	6**	24	33
Total	11	24	26	61
Per cent	18.0	39.4	42.6	100.0

*At time of delivery of fetus or, if undelivered, at time of death of mother.
**Includes one death of mother during delivery.

TABLE 16—MATERNAL DEATHS BY PERIOD OF GESTATION* AND AGE AT TIME OF DEATH, FRANKLIN COUNTY, OHIO, 1948-1952

Period of gestation	Age of mother at death, years						
	15-19	20-24	25-29	30-34	35-39	40-44	Total
Died undelivered	—	2	4	3	1	1	11
I Under 20 weeks	—	1	2	1	1	—	5
II 20-27 weeks	—	—	1	1	—	—	2
III 28-35 weeks	—	—	—	—	—	1	1
III 36-40 weeks	—	1	1	1	—	—	3
Died postpartum or postabortal**	5	9	8	15	10	3	50
I Under 20 weeks	1	2	1	4	2	1	11
II 20-27 weeks	1	1	1	2	—	—	5
III 28-35 weeks	—	2	—	2	—	—	4
III 36-40 weeks	3	4	6	7	8**	2	30
Total	5	11	12	18	11	4	61

*At time of delivery of fetus, or if undelivered, at death of mother.
**Includes one who died during delivery.

TABLE 17—SUMMARY OF CHARACTERISTICS OF MATERNAL DEATHS BY YEAR OF DEATH, FRANKLIN COUNTY, OHIO, 1948-1952

Characteristic	Total	1948	1949	1950	1951	1952
Total Cases Studied	82	22	14	17	11	18
Maternal Deaths*						
Number	61	22	11	11	7	10
Per cent of cases	74.4	100.0	78.6	64.7	63.6	55.6
Color						
White	51	19	10	9	6	7
Nonwhite	10	3	1	2	1	3
Age at Death						
Range in years	16-42	16-42	18-37	24-41	22-39	18-38
Average age	29.5	28.0	30.5	31.9	29.8	29.1
Place of Death						
Hospital	57	22	8	10	7	10
Home	4	—	3	1	—	—
Autopsies Performed						
Number	34	14	6	6	2	6
Per cent	55.7	63.6	54.5	54.5	28.6	60.0
Type of Case						
Abortion	12	10	—	—	1	1
Ectopic gestation	4	2	—	—	—	2
Cesarean section	13	2	5	2	2	2
Other	21	6	5	5	3	2
Undelivered at time of death	11	2	1	4	1	3
Cause of Death						
Hemorrhage	12	4	1	1	3	3
Infection	14	6	3	3	1	1
Toxemia	12	3	2	3	2	2
Cardiac	8	5	2	1	—	—
Embolism	5	1	1	—	1	2
Other	10	3	2	3	—	2

*Determined "maternal death" by majority vote of the members of the Columbus Obstetric-Gynecologic Society.

embolism. These two conditions together accounted for 21.3 per cent of the deaths.

8. Four ectopic pregnancy cases are included in the 61 deaths. One of the four patients was not subjected to operation. She died a very few minutes after arriving in an emergency room, of asphyxia following aspiration of vomitus and neither patient nor personnel knew she was pregnant until an autopsy was performed. In spite of surgery the other three patients died.

9. Eighteen per cent of the maternal deaths occurred before delivery. Of those which occurred following delivery, 38.0 per cent died within the first 24 hours. Another 24.6 per cent died by the end of the first week postpartum. Thus, two-thirds of the women of this series of maternal deaths who were delivered before they died, were dead at the end of the first week postpartum.

10. Twelve of the maternal deaths (Table 16) occurred in connection with "abortion." The term abortion is used herewith to denote termination of a pregnancy with gestation of less than 28 weeks.[9,10] Of the 12 abortions, five were spontaneous, three were therapeutic (including hysterotomy), and four were allegedly criminally induced.

11. A live born fetus was obtained in 42.6 per cent of the 61 cases. One set of live born twins was delivered at 36 weeks of gestation, by cesarean section; there were no other multiple pregnancies. Considering the fact that 27 of the 61 cases included either a previable or undelivered fetus, only 34 fetuses could have possibly survived. Actually, 73.5 per cent of the 34 fetuses were salvaged! As a comparison, in the Minnesota Study[11] 46.4 per cent of the "children" were born alive and survived (68 patients); Ross[25] reports a fetal salvage of 49 per cent in a rural state (844 obstetric deaths).

CONCLUSIONS

1. The Maternal Mortality Study for Franklin County, presented herewith, is the first of its kind for any given area in Ohio covering five consecutive years, and using international standards of nomenclature. Various reports have been published previously in Ohio, but they do not meet these stipulations.[2,3,4,5]

2. The study is practical, feasible and with a few alterations can be adapted to any other community in Ohio. By maintaining uniform standards of nomenclature and statistics all communities may be compared.

3. This study offers abundant material, factual in nature, for a postgraduate educational training program applicable to local physicians who practice obstetrics, and to the lay public which provides the patient material.

4. The Maternal Mortality Study, as described, demonstrates a need for further education in obstetrical problems, including *early* diagnosis of complications and adequate prenatal care. As previously described[7] we may also conclude that where a lack of proper care of a given patient was ascribed to failure on the part of the attendant, it is probable that this failure was not attributable to neglect or carelessness. Rather, ignorance and insufficient training of the attendant prevented him from giving a high quality of care which he attempted to provide, and further prevented the understanding on his part of the fact that he was incapable. Similar observations have been made, for instance, in Philadelphia by Carrington and Willson[26] who declare 75 per cent of the maternal deaths due to eclampsia were thought to have been preventable; findings suggest the physicians were unimpressed

TABLE 18—MATERNAL DEATHS CLASSIFIED BY PREVENTABILITY OF AND RESPONSIBILITY FOR THE DEATH, FRANKLIN COUNTY, OHIO, 1948-1952

Preventability and Responsibility	Number	%
Nonpreventable	13	21.3
Preventable	48	78.7
Patient responsible (P_1)	(10)	(16.4)
Personnel responsible (P_2)*	(38)	(62.3)
Total	61	100.0

*Includes one case voted P_2 predominantly, but also P_1 to a certain degree.

TABLE 19—CAUSES OF MATERNAL DEATH, FRANKLIN COUNTY, OHIO; MINNESOTA, NORTH CAROLINA AND ILLINOIS MATERNAL MORTALITY STUDIES

	Franklin County, Ohio		Minnesota[11]		North Carolina[25]		Illinois[24]	
Period of Study	5 years 1948-1952		1 year 1950-1951		4 years 1946-1950		2 years 1948-1950	
Total Deaths	61		68		1000		237	
Cause compared:	Number	%	Number	%	Number	%	Number	%
Hemorrhage	12	19.7	9	13.2	259	25.9	*	35.5
Infection	14	22.9	7	10.3	73	7.3	*	13.1
Toxemia	12	19.7	13	19.1	264	26.4	*	25.7
Heart Disease	8	13.1	4	5.9	64	6.4	*	
Embolism	5	8.2	*	*	74	7.4	*	25.7
Anesthesia	2	3.3	4	5.9	25	2.5	*	
**	**		**		**			**

*Figures not available
**Remaining causes not listed

TABLE 20—MATERNAL DEATHS BY PERIOD OF GESTATION AND PRENATAL CARE, FRANKLIN COUNTY, OHIO, 1948-1952

Period of gestation	Prenatal Care				
	Adequate	Inadequate	None	Unknown	Total
Died undelivered	5	3	1	2	11
I Under 20 weeks	3	—	1	1	5
II 20-27 weeks	1	—	—	1	2
III 28-40 weeks	1	3	—	—	4
Died postpartum or postabortal	24	9	6	11	50
I Under 20 weeks	2	—	3	6	11
II 20-27 weeks	1	1	3	—	5
III 28-40 weeks	21	8	—	5	34
Total	**29**	**12**	**7**	**13**	**61**
Per cent	**47.5**	**19.7**	**11.5**	**21.3**	**100.0**

with the seriousness of progressive signs of pre-eclampsia which they *noted* and recorded.

5. Obviously, the accoucheur must make every effort to obtain permission for an autopsy upon his patient, should she die.

6. There is a distinct need for more *accurate* and *complete* records on the obstetrical patient. Particularly the need is demonstrated in the physician's office, the record of hospitalization and the execution of the official birth and death certificates. In a number of certificates examined, incorrect nomenclature was used by the physician, and occasionally no mention was made of the pregnant state of the deceased, either recent or remote, as a secondary or contributing cause of death.

7. Minimum standards for obstetrical care must be adopted as a criterion for education and for mortality studies. Several excellent schedules of standards have been published recently and may be used as a guide.[11,23]

8. The authors recommend the inauguration of a maternal mortality study, similar to the one herein described, in other counties of the State of Ohio. The plan herein presented is believed to be sound as a guide in the formulation of other local plans. Additional help may be obtained from other established outlines.[7,8,11,24,25]

Acknowledgment. The authors gratefully acknowledge the cooperation and assistance of members of the medical profession of Franklin County, Ohio; and particularly Dr. Ollie M. Goodloe, Columbus health commissioner; Dr. John D. Porterfield, Ohio director of health; Dr. Margot Hartmann, chief of Child Hygiene Division, Ohio Department of Health, and especially the statistical unit of that Department; Dr. Robert Evans, the County coroner; hospital authorities, record room staffs and members of the house staffs of Columbus hospitals. Further, members of the Columbus Obstetric-Gynecologic Society have given of time and effort in annual meetings and in their private practices to support the study. Without the continued cooperation of all of these individuals, the completion of this study would have been impossible.

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Rheumatic Fever

A Pediatric Review

ROBERT A. LYON, M. D.

ETIOLOGY

ALTHOUGH the hemolytic streptococcus is the accepted agent initiating rheumatic fever, only a small percentage of streptococcal infections produce the typical signs of rheumatic fever, notably the joint pains. Observations by Rantz and his co-workers[1] suggested that such infections, especially in children less than 4 years of age, often caused only mild colds. In older children, who had had several mild infections of this kind, the invasion of a streptococcus stimulated sudden, acute disease characterized by high fever, exudative tonsillitis and possibly rashes. In this latter group, rheumatic fever was most apt to occur, sometimes with joint pains but sometimes without any such symptoms of rheumatic fever except an elevation of temperature and abnormal changes in the electrocardiogram.

The nature of the body's response to streptococcal infection in the rheumatic patient differs in some ways from that of the non-rheumatic patient. The development of new techniques for analysis of the protein fractions of the blood has intensified the search for these differences. Elevations of serum fibrinogen, alpha and gamma globulins and a decrease in albumin in rheumatic patients have been reported recently by Jackson and his co-workers.[2] Other studies by Kelley et al.[3] have demonstrated an elevation of serum mucoproteins in rheumatic fever patients during acute stages of the disease.

Although these protein measurements seem to provide accurate indices of the stage of activity of rheumatic fever, it is doubtful yet whether they are specific for the disease or whether they supply clues to the mechanism of the infective process.

TREATMENT

Corticotropine (ACTH) has given good results in the treatment of acute rheumatic fever. The problem remains whether all patients should be treated in this manner. A report by Wilson and her co-workers[4] during the past year emphasized the good results obtained with corticotropine in daily doses of 1 to 5 mg. per kilogram of body weight for about a week. Some patients had recurrences which required a second course of treatment.

A comparative study of the effectiveness of cortisone, corticotropine (ACTH), or the customary salicylates was conducted recently by Rowe, McKelvey and Keith.[5] Few if any differences in the results could be ascertained. Salicylates, which were the least expensive and the simplest of the three drugs to administer, removed symptoms and prevented cardiac damage as well as the other medicines. Unfavorable reactions were rare with the use of any of these types of therapy but there was frequently a recurrence of symptoms of rheumatic fever when the cortisone or ACTH were withdrawn. A second course was needed in about half of the author's series of patients.

PREVENTION

One of the most fruitful fields in the field of rheumatic fever has been the prevention of recurrences of the disease. Following the first attack of rheumatic fever the patient receives either a sulfonamide or penicillin daily for a period of 2 to 5 years or longer. The procedure is designed to prevent recurrences of streptococcal infections and has received the endorsement of the American Heart Association.

A recent report by Roberts[6] emphasized the excellent results and paucity of reactions encountered with the use of penicillin daily in oral doses of 100,000 units twice a day. The rate of recurences was 0.0-0.4 per cent compared with the rates of 25 per cent experienced in previous decades.

Kohn and his colleagues[7] have employed an intensive course of penicillin for one week of each month to protect patients from streptococcal infections. During the week, 2 tablets of 100,000 units each were given every four hours. During the succeeding three weeks no therapy was given. Recurrence rates of 1.5 per cent occurred in the treated children over a three year period and in untreated control studies rates of 19 to 20 per cent were encountered.

Other methods for prevention of rheumatic fever have been directed towards prompt treatment of infections, especially exudative tonsillitis which appears to be streptococcal in origin. Large doses of penicillin are highly effective for such purposes but other antibiotics may be

Submitted March 12, 1954.

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used if penicillin causes untoward reactions. Aureomycin was found effective by Houser et al.[8] for such infections. The dosage used most often was 1.0 Gm. at once and 0.5 Gm. every six hours for a period of five days. The patients were closely watched for evidence of recurrence of the infection and given a subsequent course of treatment when necessary.

EMOTIONAL REACTIONS

Since the treatment of rheumatic fever and its accompanying heart disease often involves long periods of physical inactivity, the normal lives of children are greatly disrupted. Fear of the cardiac complications may often be a cause of worry for both the parents and child. Under the stress of such anxieties and pressures, some patients develop abnormal behavior patterns and emotional imbalances. Studies by Brazelton, Holder and Talbot[9] emphasized the need for sympathetic nursing and careful planning of the future programs of rheumatic children to avoid psychological disturbances and to speed recovery.

A similar investigation has been carried out by Weihl and his associates in the Cincinnati area (to be published). They found a large number of adolescent children who had entirely erroneous ideas of the severity of their heart disease and of the purpose of repeated physical examinations and conferences in association with the regularly administered drugs for prevention of rheumatic fever. It was also evident that more and more children were being referred to physicians or to clinics for symptoms suggestive of heart disease which were minor disorders but had aroused undue anxiety in parents.

To gain a more thorough knowledge of the attitudes of patients and their parents towards heart disease, more than 50 adolescent children whose ages ranged from about 10 to 20 years were interviewed and examined by physicians, a nurse, a social worker, a psychologist and a psychiatrist. Many of the rheumatic patients came from lower economic strata of the community where broken homes and unstable family situations were fairly frequent and anxiety and insecurity seemed to be fairly prevalent. Under such conditions, chronic illness such as rheumatic fever, and restrictions of activity requiring a withdrawal from normal life were sufficient to produce abnormal behavior in a large proportion of the group.

RECOMMENDATIONS

From their observations, Weihl and his coworkers have made several recommendations for the care of the child who develops heart disease.

(1) When the involvement is questionable or minimal, every effort should be made to return the patient to his normal life as quickly as possible and to assure the parents that the child will be observed frequently for any regression of the condition. Probably the greatest value of tests such as X-rays, electrocardiograms, and sedimentation tests for such patients is the confirmation to physician and family that no evidence of organic heart disease exists.

(2) When a long period of convalescence and treatment seems probable, the child and his family should be investigated thoroughly to determine the environmental and emotional factors which might obstruct the success of the program.

(3) Conferences with the patient and his family should minimize the dangers of the heart disease but gain their cooperation for a long period of observation and treatment as a means of preventive recurrences of infection.

(4) Greater leeway is given today than formerly in permitting the child to return to school and to a life of normal activity. When infection subsides, the rheumatic child can profit more from mild activity and interesting play and occupation than from prolonged bed rest.

(5) Guidance of the adolescent child into occupations not requiring heavy strain or excessive fatigue. Children of average intelligence were urged to continue their general education. Those unable to pursue schooling with any interest in learning beyond the ninth or tenth grade were urged to seek special vocational training rather than to leave school for any sort of labor or manual occupation.

(6) In the education of the laity regarding rheumatic heart disease, it seemed important today to stress the newer methods of treatment of the disease and the greater hope of prevention of serious sequelae and recurrences of infection.

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Löffler's Syndrome

In 1932, Löffler described a syndrome, characterized by asymptomatic transitory pulmonary infiltration, benign course, and eosinophilia.



A Case Record

From The University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

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PRESENTATION OF CASE

ABOUT two weeks prior to hospital admission this 53 year old white female had an acute onset of watery diarrhea associated with cramping lower abdominal pain but with no nausea or vomiting. She gave a history of black stools for two days but had been taking iron medication. She denied any constitutional symptoms. During this illness she lost 14 pounds. She had been treated with various antibiotics, without response. The patient had had pulmonary tuberculosis, with a left thoracoplasty done five years before her terminal illness. The patient stated that the nodular goiter she presented had been there since she was 18 years old.

Physical Examination: On admission the blood pressure was 110/60, pulse 120, temperature 100, respirations 30. The patient was a well-developed, fairly well-nourished white female in no apparent distress. The eyes, ears, nose and throat showed no significant findings. The trachea seemed slightly deviated to the right. There was a nodule in the thyroid gland. The right chest was clear, but dullness and decreased breath sounds were found on the left. There was a thoracoplasty defect on the left with rather marked deformity of the chest. The left border of the heart could be palpated inside the mid-clavicular line because of the defect in the rib cage. There was a questionable gallop rhythm present at times. The abdomen was generally tender to deep palpation; no masses or organs were palpable. The pulses in the extremities were feeble. The skin showed slight loss of turgor and moderate dehydration. The neurological findings were physiological.

Laboratory Data: On admission the red blood cell count was 5.5 million, hemoglobin 15.5 Gm.; the white blood cell count was 16,000 with a differential count of 3 per cent myelocytes, 86 per cent neutrophils, 10 per cent lymphocytes. The urine had a specific gravity of 1.008, a protein content of 320 mg.; 0 to 3 red blood cells and 5 to 8 white blood cells per high power field. Two stool cultures were negative. A third stool culture (on the fifth hospital day) grew Proteus vulgaris. No. acid-fast bacilli were found on smear or culture of stool. No amoebae were seen on direct swabbing obtained by proctoscopy. Blood culture was also negative.

Blood chemistry on the tenth hospital day revealed 136 meq. of sodium, 5 meq. of potassium, and 87 meq. of chlorides. Radioactive iodine uptake studies of the thyroid showed 10 per cent uptake in one hour, 23 per cent in 24 hours with 22 per cent excretion in the urine in 24 hours. The protein-bound iodine was 1.8 mcg., soluble 2.0.

On the twelfth hospital day the red blood cell count was 5.74 mil., hemoglobin 17.2 Gm., the white blood cell count 7,950 with 3 per cent myelocytes, 88 per cent neutrophils, 9 per cent lymphocytes; the white blood cells showed severe toxic granulation. Urinalysis on the twelfth hospital day showed 800 mg. of protein, 5 to 8 lymphocytes, many red blood cells and many epithelial cells per high power field.

An electrocardiogram on the third hospital day showed a prolonged systole which was interpreted as the effect of hypotassemia.

Radiographic Studies: Roentgen-ray examination of the chest showed a left thoracoplasty with complete collapse of the left lung and considerable pleural reaction in the apex. A barium enema showed a double contour to the bowel outline involving the entire colon from the sigmoid through the cecum, indicating ulcerative colitis. The terminal ileum was slightly irregular but not positively diseased. An upper gastrointestinal series was normal.

Hospital Course: The patient was placed on cortisone, belladonna, phenobarbital and intravenous glucose with added vitamins. By the second day the number of stools had markedly

decreased. On the third day the patient was able to eat a meal, the first in about two weeks. However, she began to have upper abdominal pain after ingestion of food. In view of the history of tuberculosis it was felt that the patient should receive the cortone® for only a brief period; however, when the cortone® was stopped the diarrhea and abdominal pain promptly resumed.

By the sixth day the patient was complaining of marked weakness and an electrocardiogram showed potassium deficiency. The patient was therefore placed on potassium citrate. Sigmoidoscopy showed a hyperemic, granular mucosa with bleeding ulcerations seen in the sigmoid. A biopsy of the mucosa was unsatisfactory for diagnosis. The radiographic findings of ulcerative colitis were supported by the presence of pus in the stool and the sigmoidoscopic findings, the abdominal cramps following ingestion of food and relief by bowel movements, which were liquid and frequent. The patient was placed on banthine® and ACTH. She was also given a 3,000 calorie diet with high protein and carbohydrates, bismuth subcarbonate, and codeine.

COFFEE-GROUND VOMITUS

On the tenth hospital day the patient began complaining of rather severe generalized abdominal pain, she vomited a moderate amount of coffee-ground-like material, her abdomen was distended and the bowel sounds infrequent and high-pitched. She complained of numbness and tingling in her extremities and was slightly cyanotic and dyspneic. No blood pressure could be obtained and no pulse was palpable.

A Miller-Abbott tube was inserted and 700 cc. of black liquid was obtained. Following this the abdomen seemed less distended. The patient was started on penicillin and streptomycin. She received 1500 cc. of whole blood, 500 cc. of plasma and 1250 cc. of intravenous fluid with 3 cc. of levophed.® This had no effect on the blood pressure. The fluid output on the tenth hospital day was 800 cc. of gastric aspiration and 200 cc. of urine.

On the eleventh day the patient was placed on cedilanid® and received 500 cc. of blood and 500 cc. of glucose fluid. Her total output was 1160 cc. On the tenth hospital day the temperature, which had remained only slightly elevated, began to rise and reached a peak of 106°F. on the eleventh day. The patient continued in a state of shock with no blood pressure obtainable and no pulse palpable, and she developed moist rales in her right lung. She continued oliguric, her output on the twelfth day being 295 cc.

By the afternoon of the twelfth day the patient responded rather poorly and had developed livor and mottled cyanosis. Her temperature dropped from 105° to 98°F. Numerous rales were heard in the right lung. A cut-down of an artery was done and intravenous fluid started. The arterial pressure rose. However, the patient expired very shortly thereafter.

CLINICAL DISCUSSION

Dr. W. F. Bradley: In the presentation of this patient we have to consider several interesting aspects. First, we have a patient who was admitted to the hospital with a two-weeks' complaint of diarrhea and weakness. She had been on some antibiotic therapy, which nowadays is more common than not and which often complicates the picture when you are trying to make a specific diagnosis. The patient's recent antibiotic therapy had been predominantly aureomycin, and aureomycin and terramycin® frequently produce severe gastrointestinal symptoms, notably diarrhea, proctitis, itching, etc. The patient and her husband denied that she had had previous bowel symptoms or bowel difficulties. The clinical history also revealed that the patient had had pulmonary tuberculosis about five years ago which had been apparently successfully treated by thoracoplasty.

It was decided to treat the patient conservatively at first, and she was placed on belladonna and phenobarbital, which failed to bring any relief. Next we decided to try cortisone. Since one of my earlier patients had died because a dormant tuberculous process was activated with cortisone, I used this drug on this patient with considerable fear and insisted that only a short course be given. She responded quite well and was able to eat for the first time in two weeks. As soon as the cortisone was stopped, however, her complaints recurred.

SIGMOIDOSCOPY

The findings at sigmoidoscopy were typical of ulcerative colitis. We saw a bleeding, granular, friable mucosa which confirmed our clinical and radiological impression that the patient had ulcerative colitis. Because of the short duration and history have no right to speak of "chronic" ulcerative colitis, in spite of the radiographic findings which suggested a thickening of the bowel wall of some duration. We also considered the possibility of tuberculous colitis since the patient was known to have had tuberculosis. All bacteriological examinations, however, were negative for tuberculosis and the patient responded well to cortisone. So we concluded that the patient had had non-specific ulcerative colitis, more or less an aggravation of the so-called irritable bowel syndrome in which episodes of diarrhea become more and more severe and more frequent until the patient ends up with fulminating ulcerative colitis. For this reason we decided on ACTH therapy.

On her tenth hospital day the patient developed severe generalized abdominal pain with acute distention. She vomited considerable amounts of coffee-ground material and went into shock. We

feared that one of the complications of acute ulcerative colitis had taken place: Either a severe intestinal hemorrhage had occurred or a perforation had taken place. We decided on the latter possibility. We then treated her with blood transfusions, plasma transfusions, antibiotics and intestinal decompression. The patient continued in a state of shock with rising temperature and increasing abdominal distention. She became severely oliguric and rapidly turned for the worse. She died three days after the onset of the final complication.

SHOCK

The question as to the origin of this sudden shock condition has more than one answer. True, she had sufficient reason to develop it on the basis of a peritonitis caused by perforation of a specific or non-specific ulcerative colitis. However, another possibility must not be overlooked. We must remember that the patient had a thoracoplasty five years before and many of those patients become potential candidates for pulmonary hypertension and right heart failure. Terminally the patient developed sudden and acute pulmonary edema with frothing at the mouth and died in a matter of minutes. It could well be possible that the patient died in acute pulmonary edema with right heart failure as a consequence of chronic pulmonary hypertension which in turn was produced by extensive pulmonary disease.

In patients who die with pulmonary tuberculosis autopsies reveal anywhere from 28 to 85 per cent involvement of the gastrointestinal tract. The fact that the patient had been treated with cortisone and ACTH makes me feel that the patient had a tuberculous colitis rather than the non-specific form, activated from a pulmonary or extrapulmonary tuberculosis by this treatment. We feel that she had a generalized peritonitis due to rupture of an ulcer in the region of the cecum and in the final analysis we also feel that the inflammatory process in the gastrointestinal tract was probably tuberculosis which might have been reactivated or at least furthered by the use of cortisone and ACTH.

CLINICAL DIAGNOSIS

1. Ulcerative colitis, probably tuberculous, with perforation of the cecum and generalized peritonitis.
2. Pulmonary tuberculosis of questionable activity.
3. Acute pulmonary edema from right heart failure due to chronic pulmonary hypertension.
4. Left thoracoplasty.

GENERAL CLINICAL DISCUSSION

Dr. Jack Widrich: A bronchogram taken five years ago also showed bronchiectasis extending towards the right upper lobe. It appears that this lobe too was not functioning well and that most of the respiratory function was carried by the right lower and perhaps middle lobe.

Dr. Bradley: The possibility of a persistent or reactivated tuberculous process we considered in spite of the fact that the laboratory findings were negative.

Medical Student: Could the patient have suffered from tuberculosis of the kidney?

Dr. Bradley: On what basis would you put this question?

Medical Student: I thought the severe proteinuria with the absence of many white blood cells would suggest a severe lower nephron nephrosis.

Dr. Bradley: We considered the proteinuria as evidence of toxemia.

Dr. B. M. Oser: How do you explain the large quantity of black fluid removed from the stomach?

Dr. Bradley: We feel that the patient had a bleeding lesion in her lower gastrointestinal tract and that blood regurgitated into the stomach.

Dr. E. K. Ryder: Have you previously encountered an ulcerative colitis which perforated because of cortisone therapy?

Dr. Bradley: I do not know if it perforated because of the therapy, but such is reported in the literature. All the cases which I have treated have markedly improved with the exception of this one.

Dr. Oser: How do you explain the terminal pulmonary edema?

Dr. Bradley: We started pumping fluid into her while she was already in profound heart failure.

PATHOLOGIC DIAGNOSIS

1. Chronic fibrocaseous tuberculosis, bilateral.
2. Collapse of left lung with chronic lung abscess and bronchiectasis.
3. Generalized amyloidosis.
4. Subacute non-specific ulcerative colitis.
5. Perforation of cecum with fibrinopurulent peritonitis.
6. Recent focal infarction of myocardium.
7. Nodular colloid goiter.
8. Cholesterolosis of gallbladder.

PATHOLOGIC DISCUSSION

Dr. E. von Haam: The body was that of a white female weighing approximately 110 pounds. The left chest wall was greatly deformed and the pleural cavity compressed due to an old thoracoplasty. The abdomen was distended. The peritoneal cavity contained foul-smelling thin yellow exudate. Both pleural cavities were obliterated by dense fibrous adhesions. The heart was slightly enlarged and showed dilatation of both ventricles.

The left lung was small and contracted and

weighed only 95 grams. It contained a collapsed cavity. The bronchi were thick-walled and tortuous. The upper lobe of the right lung showed numerous caseous and fibrotic nodules. The bronchi showed tubular bronchiectasis. The lower lobe was crepitant and contained multiple scattered areas of consolidation. The spleen was enlarged, dark red and firm. The liver appeared normal.

The mucosa of the stomach and small intestine appeared normal. The colon was distended and its mucosa showed multiple large irregular areas of ulceration with highly edematous and deep purple mucosa between the areas of ulceration. A perforation of one of the ulcers distal to the ileocecal valve was loosely covered by omental fat. Both kidneys were enlarged, smooth and had a pale surface. The cortical substance appeared swollen. The genital organs appeared involuted. The thyroid was enlarged and nodular.

MICROSCOPIC EXAMINATION

The microscopic examination showed small areas of focal infarction in the heart muscle. Sections of the lungs showed fibrocaseous tuberculosis in the left lung and the apex of the right lung. The collapsed cavity histologically resembled a chronic pulmonary abscess lined by a thick pyogenic membrane. The bronchi of both lungs, particularly of the left, showed bronchiectasis. Sections through the spleen and liver showed an advanced degree of amyloidosis. Sections of the colon showed amyloidosis of the smaller vessels, marked edema of the submucous layer and atrophy with ulcerations of the mucosa. Amyloid was also present in the adrenals and in the kidneys, in the latter producing numerous hyaline and waxy casts. The mesenteric lymph glands also contained amyloid.

In summary then we feel that the patient suffered from systemic amyloidosis brought about by the chronic inflammatory process present in both lungs. The latter was partly tuberculous in nature, partly non-specific as a result of chronic bronchiectasis.

The amyloid disease produced two groups of symptoms in this patient: those from the kidney and those from the intestines. The symptoms from the kidney consisted of severe proteinuria and probably uremia. The only blood urea nitrogen determination made while the patient was alive showed 61 mg. Amyloidosis of the intestines produced a severe diarrhea with atrophy and ulcers in the colon. The latter symptoms proved to be the main clinical features of this case and dictated the clinical diagnosis. The final event of course was precipitated by the intestinal perforation with diffuse peritonitis.

GENERAL DISCUSSION

DR. BRADLEY: The incidence of amyloidosis in patients with chronic long-standing pulmonary tuberculosis or other infectious processes is well known and as a matter of fact is pretty high, and I would have a difficult time arguing with this diagnosis. It only seems amazing to me that the patient did not complain at all of her pulmonary disease and that nobody had an idea how badly off she really was.

MEDICAL STUDENT: What was the etiology of the ulcerative colitis?

DR. VON HAAM: I would say it was bacterial in origin but precipitated by the intestinal amyloidosis. Of course one could also speculate as to a uremic colitis. The edema and the hemorrhages which were present would well fit the picture of a uremic colitis.

DR. BRADLEY: From your description the adrenals must have been pretty much degenerated. This would mean that our ACTH therapy probably was little effective.

DR. VON HAAM: Dr. Bradley, why did you not consider the kidney in your differential diagnosis? I was very glad that this was mentioned in the clinical discussion. After all, there was a heavy albuminuria and the rising blood urea nitrogen.

DR. BRADLEY: We did not call a kidney specialist for consultation. The patient appeared quite toxic and her toxemia explained to us the urinary symptoms. Sometimes one group of symptoms will be so much in the foreground that you miss the really significant pathology.

DR. VON HAAM: The important fact we learned from this case was that the patient would have died even if we had successfully treated her colitis. Perforation probably would not have taken place, but sooner or later the patient would have succumbed to uremia.

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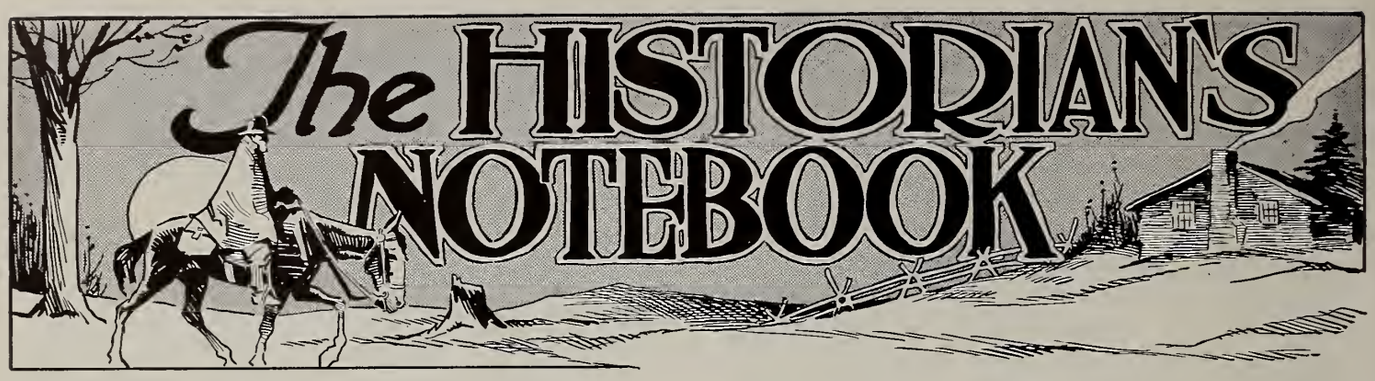
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Relationship of Malnutrition To Certain Diseases

It is well known that hookworm disease, malaria, and tuberculosis are intimately related to malnutrition in many persons who suffer from these diseases, but whether or not the relationship is causal defies affirmation except in certain individual situations.

The sufferer of malaria or hookworm disease may be malnourished because of anemia that reduces his productive and earning capacity and therefore his ability to provide for his food needs. Or the malnourished person, as a result of diminished resistance, may fall an easy victim to such diseases.

Whatever may be the relationship, it is clear that the well-being of the individual is compromised by malnutrition as well as by certain specific diseases—INSTITUTE OF INTER-AMERICAN AFFAIRS, *Pub. Health Reports*, November, 1953.



Cincinnati's "Old Cunny," A Notorious Purveyor Of Human Flesh

LINDEN F. EDWARDS, Ph. D.

FOR the sake of accuracy and to be truly interpretative the historical account of any era should include a record of the evil deeds of disreputable characters as well as the good deeds of honorable ones, albeit the tendency is to disregard the former in order to glorify the latter, because of their greater appeal to the pride and esteem of their fellow countrymen.

The medical colleges and the good citizens of Cincinnati during the nineteenth century could well boast of their outstanding professors of anatomy, such notables for example, as Doctors Cilley, Clendenin, Cobb, Comegys, Gobrecht, Gross, Judkins and others too numerous to mention—names which still grace the rolls of "Ohio's Medical Hall of Fame." It is not the object of this paper to detract one iota from the laurels of these professors of anatomy; rather, the purpose is to depict some of the deeds and something of the character of a villainous individual by the name of William Cunningham, a "professional resurrectionist," upon whom the professors relied for procuring their anatomical material.

THE DRAY-MAN BOGEYMAN

More stories were told about Cunningham than of any other of the resurrectionists in Ohio, of his grave robbing episodes and of his escapades in eluding law officers. He was the bogeyman of all ill-behaved children in the environs of Cincinnati during the period when he plied his trade in corpses, which was between the years 1855 and 1871. He was known locally by various names, including Old Man Dead and The Ghoul, but he was more familiarly called "Old Cunny," not simply because it was a contraction of his real name but since he was as cunning as the proverbial fox, and due to his adroitness and daring, he was deserving of the cognomen.

Submitted March 3, 1954.

The Author

● Dr. Edwards, Columbus, is professor of anatomy at the Ohio State University.

He was born in Ireland in 1807 and is described as having been a big raw-boned man with muscles like Hercules, a protruding lower jaw and an insatiable thirst for hard liquor. During the day he was ostensibly a dray-man, but at night he plied his trade as a professional resurrectionist, supplying the medical colleges, of Cincinnati with cadavers which he and his hired helpers exhumed from the local cemeteries.

According to a Cincinnati physician, who knew him in a business way, "Cunny was an expert in his business. . . . Usually he took the body to town in a buggy sitting in the seat beside him. The corpse was dressed up in an old coat, vest and hat. He would hold the reins in his right hand while he would steady the corpse with his left arm around the waist of his silent companion. Whenever people passed and the corpse would gravitate forward and downward Cunny would slap his inoffensive partner in the face and say to him 'Sit up! This is the last time I am going to take you home when you get drunk. The idea of a man with a family disgracing himself in this way!' "[1]

OLD CUNNY'S CUNNINGNESS

Illustrative of Old Cunny's cleverness are the following incidents related about him. One night between the hours of eleven and twelve o'clock he and two of his confederates stopped at a saloon in Carthage to have a drink. His identity being known by almost everyone in the environs of Cincinnati and his nightly movements always

arousing suspicion, after he and his helpers had departed several of the patrons of the saloon organized themselves into a posse and proceeded to follow the ghouls to the cemetery used by the City Infirmary in the rear of that institution. The party in pursuit surrounded the cemetery just as the ghouls were in the act of raising two subjects from their graves and commenced firing promiscously at them. His two helpers escaped into an adjoining woods but Old Cunny stood his grounds and obstinately refused to obey the command to hold up his hands. Finally when one of the members of the party drew a bead on him with a rifle which failed to go off when the cap snapped he reluctantly gave himself up and begged them to spare his life.

Old Cunny was then piled into his conveyance and accompanied by his captors was forced to drive back to Carthage. On their return to that village he persuaded his captors to stop at the saloon where he bought them several drinks. When they were properly mellowed he was released and permitted to return to Cincinnati with his empty wagon. However, instead of continuing toward that city he circumvented the route and returned to the cemetery, during which time his doughty captors merrily dispersed to their homes. Meanwhile his helpers having been well trained in their duty had returned to the scene of their ghoulish task, had hooked the two subjects from their graves and placed them in sacks all ready for transportation to one of the medical colleges.[2]

TWO BODIES TWICE SNATCHED

On another occasion he and two of his helpers were apprehended on Reading Road near Walnut Hills with their booty which consisted of two bodies which they had just exhumed from a cemetery near Hartley and were concealed in gunny sacks. The three were immediately placed under arrest and taken to the Ninth Street police station and the bodies were delivered to a near-by funeral establishment for subsequent identification.

The following morning the suspects were released on bail and that afternoon two unassuming individuals, unknown to the attendant in charge, called at the undertaker's establishment and claiming they were from the coroner's office demanded the bodies for the purpose of holding an inquest on them. The two bodies were released without hesitation. Upon the arrival of the proprietor when told of the incident he contacted the coroner's office only to learn that the bodies in question had not been sent for or been seen. Inasmuch as there were no *corpi delicti* as evidence no case could be made out against Old Cunny and he and his confederates were released.[3]

In the *Cincinnati Daily Gazette*, under date of November 22, 1870, is a news item to the effect that a body delivered to one of the medical colleges of that city "was stolen by the enterprising sawbones of a rival establishment during the night. Old Cunny was therefore compelled to make another midnight expedition last night much to his disgust—not that he dislikes the business, but that he is now getting old, and that which was once pleasant recreation has now become somewhat of a burden." Wonder if it ever occurred to that reporter that there is a strong likelihood that Old Cunny himself might have been the guilty one who "stole" the body and re-sold it to a rival institution? Such episodes were known to occur.

Evidently not all of Old Cunny's contraband was destined for the anatomy laboratories in Cincinnati, as judged from a news item in the *Cincinnati Daily Gazette*, dated January 20, 1870. According to this news report "Cunningham, the resurrectionist, deposited a box at the U. S. express office marked 'Glass with care, C. O. D. Dr. M. P. Hayden, Leavenworth, Kan.' Suspicions of the company's agents were excited and when they opened the box it contained the body of a negro woman prepared for the dissecting knife and served up in a sack. The freight was returned to Mr. Cunningham."

A GHASTLY REVENGE

Old Cunny's villainous nature is well illustrated in a story told of him when he took ghastly revenge on some frollicking medical students who had played some sort of a joke on him. According to the story, he became so enraged with the students that he knowingly dug up the body of a smallpox victim which he delivered to the dissecting room, as a result of which the unprotected students promptly became infected with the disease.[4]

Although Cunnigham probably was booked in the police records of Cincinnati more often than any other of its citizens during his time not all of the charges brought against him were based on his resurrection activities. As mentioned previously, he was addicted to strong liquor and because of that weakness he was occasionally booked on charges of drunkenness and disturbance of the peace. Thus, for example, in the *Cincinnati Daily Gazette* on January 13, 1870, we read that "William Cunningham, an express driver, who will be remembered by all who have attended the medical colleges in this city, managed to get arrested last night. He first fired his brain with whisky then fired off an enormous revolver on Central Avenue." The report goes on to say that he had on his person more than seventy dollars in greenbacks, a sum according to the write-up slightly larger than usual for station-house visitors.

Evidence that Old Cunny enjoyed a lucrative income from his nefarious business is furnished by an editorial in the *Cincinnati Daily Enquirer* on February 21, 1871. It comments upon the poor

conditions of the Wesleyan Cemetery in that city, pointing out that "several of the graves look as though they had been robbed by a professional body-snatcher. The heads of the graves about two feet square in area are sunken lower than the rest. . . . Indeed after a consideration of the ease with which any one can get into the grounds, it is not a matter of surprise if Cunny or some other professional has often paid nocturnal visits to the Wesleyan and obtained subjects for the various medical colleges." It then goes on to say that "When men of small means, and endowed with a bare living, can afford to purchase fine residences and building sites, can drive home four-hundred dollar carriages right from the manufacturer things do begin to look somewhat suspicious." It may be assumed that by inference the editorial writer refers to none other than William Cunningham.

"THE CHAMPION RESURRECTIONIST CAUGHT"

As is the usual fate of all culprits who fail to learn that "crime does not pay," the law finally caught up with the hero of this tale. Old Cunny's end is best described in a feature article which appeared in the August 31, 1871, issue of the *Cincinnati Daily Enquirer*, entitled "The Champion Resurrectionist Caught." Under this caption it is pointed out that

> "Everybody knows 'Old Cunny,' the resurrectionist, whose occupation for many years past has been to supply the various medical colleges of the city with subjects for dissection, and, who, it is understood, has amassed quite a handsome competency at his contraband employment.
>
> "Twelve or fifteen years ago, when he was in the prime of manhood, Cunny was so adroit and careful, though daring withal, that he carried on the business almost without molestation. But of late years his increasing age and infirmity have several times thrown him into the hands of the officers, though by singular good fortune he has hitherto escaped punishment."

The news item then goes on to state that

> "Yesterday morning about one o'clock the attention of two police officers was attracted by the figure of an old man driving at a rapid rate down a Cincinnati street followed by a crowd of men and boys running after him, hooting and hollowing 'Stop him! Shoot him!' and the like. The officers called him to stop but he only laid whip to his horse and drove past them. The horse, however, was lame, and the load in the wagon seemingly heavy and after a short race one of the officers grasped the bridle while the other took charge of the driver. The driver was Old Cunny, who, returning after a night's work at his ghoulish employment, had been delayed on his road home by an accident to his vehicle. In the wagon was found a sack containing the dead body of a man while a similar package on the seat beside him contained the remains of a child, a boy ten or twelve years old."

Cunny was taken to the police station and ensconsed behind iron bars; his contraband was put in charge of the coroner and he entered a plea of not guilty. After paying bail to the sum of $300.00 he was released from custody to answer to the charge of illegal possession of dead human bodies at the next session of the Common Pleas Court.

On September 12, 1871, there appears a statement in the same newspaper to the effect that Cunningham had been indicted on five counts. No record could be found as to whether or not he appeared in Court to answer these charges or whether or not he was found guilty and sentenced. The next news we hear of him is in the October 23, 1871, issue of the newspaper in which it is mentioned for the first time that Old Cunny was a patient in the Cincinnati Hospital and that he "regarded the announcement of his demise yesterday morning as an error." The news item goes on to say that he was suffering a temporary derangement of his system from the use of too much poor whisky but that he promised to be out in a few days ready for business, which he claimed was being sadly neglected during his illness.

AN APPROPRIATE FINIS

It is not known whether or not he was able to fulfill his promise. However, it is known from the announcement in the local daily press that Old Cunny met his demise on November 2, 1871, at the age of 64. According to Juettner that was not the end, however, of his earthly remains, for on authority of this author prior to Cunningham's death he had sold his body to the Medical College of Ohio and when he died it was turned over to that institution by his "bereaved widow" who managed to get an additional $5.00 bill for his giant carcass. This author also made the claim that at the time when he wrote the statement "the skeleton of Old Cunny is to this day the *pièce de résistance* in the museum of the Medical College of Ohio."[6]

Juettner's claim as to the eventual fate of Old Cunny's skeleton has been verified by a statement received recently from the Department of Anatomy, University of Cincinnati, College of Medicine, where the skeleton is now housed.

This is not the last we hear of Old Cunny's widow, who has been described as being "a bony, brawny-jawed Irish woman, with a mouth like an alligator." She had evidently taken up Old Cunny's business where he left off, judging from a news item that appeared in the *Ohio State Journal* of December 6, 1878, under the date line Cincinnati, December 5. According to this news report, a gang of resurrectionists consisting of five persons was arrested in that city, included among which were two women, one of whom was "the widow of Cunningham, of former notoriety in this business."

Upon such depraved characters as the Cunninghams did the anatomists of the nineteenth century have to rely for the procurement of their ana-

tomical subjects prior to the passage of anatomy laws which made it unnecessary to resort to the nefarious and odious practice of body snatching. Inasmuch as the identities of the procurers and of the bodies which they delivered to the medical colleges were unknown to the anatomy professors, all business transactions having been carried on through an intermediary person—usually the janitor—the professors were consequently absolved of being a principal or accessory to the crime of body snatching. Granted that anyone who would be so wanton as to make his livelihood by desecrating places of human sepulture was deserving of all the villifying names hurled at him, nevertheless we should not lose sight of the fact that the sins of commission of the ghoulish resurrectionists were made possible by sins of omission of the public and of their representatives in the legislative halls who refused for so many years to support an anatomy law, which, as time has proved, abolished the need for resurrectionists.

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3. Cincinnati Daily Enquirer, February 3 and 4, 1871.
4. Juettner, loc. cit., 395.
5. Cincinnati Daily Enquirer, January 3, 1872.
6. Juettner, loc. cit., 395.

What's Old in Medicine

Those who think of specialization as a development of our day may be a little startled to find that Herodotus, in *A History of the Persian Wars*, made the following note on a peculiarity of Egyptian ways:

> "Medicine is practiced among them on a plan of separation; each physician treats a single disorder, and no more: thus the country swarms with medical practitioners, some undertaking to cure diseases of the eye, others again of the teeth, others of the intestines, and some those which are not local."

And physicians of today who decry the tendency of laymen to prescribe medical treatment for one another ("Take some of these capsules, Gladys; they cured me and you're welcome to those in the bottle") may find wry amusement in Herodotus' observation on medical practice in Babylon at the time of Cyrus:

> ". . . the following custom seems to me to be the wisest of their institutions. They have no physicians, but when a man is ill, they lay him in the public square, and the passers-by come up to him, and if they have ever had his disease themselves or have known anyone who has suffered from it, they give him advice, recommending him to do whatever they found good in their own case, or in the case known to them; and no one is allowed to pass the sick man in silence without asking him what his ailment is."

—S. I. Roland, M.D., *California Medicine*, Vol. 80, page 69, February, 1954.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Clavicle—The collar bone was so named from its supposed resemblance to an ancient key. The term is derived from the Latin word "claviculi" which is the diminutive of the Latin "clavis," or key.

Encyclopedia—Literally meaning a circle of instruction, this term is composed of the Greek words "en," or in, and "kuklos," a circle, plus "paideia" or instruction. Hence the term came to be applied to an alphabetical summary of every branch of knowledge.

Carron Oil—This mixture of lime water and linseed or olive oil takes its name from the fact that it was used as a treatment for burns at the Carron Iron Works in Scotland.

Ecbolic—An ecbolic is a drug that hastens partuition by strengthening uterine contractions. It is composed of the Greek prefix "ec or ek" meaning out, plus "bole," denoting a throw, dart or stroke. Hence the term literally means a drug that throws out an increased stroke. Similar in origin is the term "ecbole" used in music to designate the raising or sharpening of a note.

Malachite Green—These violet-green crystals are soluble in water or alcohol and form a dye which is used as a bacteriologic stain and also as a wound antiseptic. This dye comes from a green carbonate of copper and its name is derived from the Greek word "malache" which is the name of a wild plant known as the mallow. The mineral malachite was so called because its color resembles the green leaves of the mallow plant.

Electuary — Denoting a medicinal substance which is formed into a soft mass by combination with sugar or honey and water. This term comes from the Latin word "electuarium" which in turn comes from the Greek word "ekleigma." This is composed of the Greek words "ek," or out, and "leichen," to lick, and hence it originally designated a medicine which was made so sweet with honey that it was literally "licked out" of its container.

Masturbation — A descriptive term literally meaning "to corrupt or defile by hand." It is derived from the Latin word "manus," or hand, and the Latin "stupro," to defile or corrupt.

Decease—Deceased—Coming from the Latin "decessus," or departed, this word is composed of the Latin "de or dis" meaning away and "cessus" meaning gone, or "cess" meaning to move. Thus to recede is to move back, to secede is to move between, and to decease is to depart or to move away. The term is a euphemism and is a gentle way of saying that the dead one has just moved away to join his ancestors.

—Harry Wain, M. D., Mansfield, Ohio.

Proceedings of The Council . . .

Questions Involving Membership, Legislation, Workmen's Compensation and Many Items of Miscellaneous Business Covered at March Meeting

REGULAR meeting of The Council of the Ohio State Medical Association was held in the Headquarters Office, Columbus, on Saturday night, March 27, and on Sunday, March 28, 1954. All officers and Councilors, except Dr. R. L. Meiling, Columbus, and Dr. Carl A. Gustafson, Youngstown, were in attendance. The meeting also was attended by Dr. Jonathan Forman, Editor of *The Journal;* Mr. Wayne E. Stichter, Toledo, legal counsel; Secretaries Nelson, Saville and Page; and Mr. R. Gordon Moore, News Editor of *The Journal.*

Following announcements by President Davis, the Executive Secretary gave to members of The Council lists of officers and key committee chairmen of county medical societies in their districts.

It was announced that the Fall meeting of The Council would be held at the Granville Inn, Granville, Ohio, on September 17, 18 and 19.

The minutes of the meetings of The Council held on January 16 and 17 were approved on **motion** duly made, seconded and **carried.**

MEMBERSHIP STATISTICS

Membership statistics were reported by the Executive Secretary as follows:

Ohio State Medical Association membership as of March 26, 1954—7,426, compared to a total membership of 8,068 as of December 31, 1953.

American Medical Association membership as of March 26, 1954—6,478, compared to a total of 6,941 who were 1953 A.M.A. members.

PRORATING OF DUES

On **motion** duly made, seconded and **carried,** the prorating of dues for the third and fourth quarters of 1954 for new members was authorized as follows: New members affiliating during the third quarter, $15.00; new members affiliating during the fourth quarter, $10.00.

TRANSFER OF MEMBERSHIP

The problem of membership transfers within the state, by members holding full-time Federal or state positions and subject to transfer through the nature of their employment, was discussed. By official action, The Council adopted the policy that a Federal or state employe who is a member of the Ohio State Medical Association may elect to retain membership in a county medical society of which he is a member, in event he is transferred by the agency or organization employing him, to another county of the state, or if he desires he may elect to apply for membership in the county medical society of the county to which he is transferred by the employing agency or organization.

The Council, by official action, approved the request of the Clark County Medical Society for a re-issued charter and recommended that this be approved by the House of Delegates as required by the By-Laws.

A suggestion that the State Association select an "Ohio physician of the year" was discussed. By official action, The Council reaffirmed its previous policy, namely, that the Association would not sponsor this activity.

ANNUAL MEETING

The Executive Secretary gave a report on final arrangements for the 1954 Annual Meeting, Columbus, April 12-15. Announcements of interest to the Councilors were made. Certain members of The Council volunteered to act as official hosts for guests from other state medical societies.

OHIO MEDICAL INDEMNITY

The Council was advised that the annual meeting of the stockholders of Ohio Medical Indemnity, Inc., would be held in the offices of Ohio Medical Indemnity, Inc., Columbus, on Wednesday, April 21. On **motion** duly made, seconded and **carried,** the following were authorized to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting of O.M.I. on all business matters coming before that meeting: Dr. H. M. Clodfelter, Columbus, or Dr. C. C. Sherburne, Columbus, or Mr. Charles S. Nelson, Columbus.

The Council then by official action instructed the person voting the stock of Ohio Medical Indemnity, Inc., held by the Ohio State Medical Association, to cast the votes of the Association at the stockholders' meeting for the following persons for membership on the Board of Directors of O.M.I. for the ensuing year: Dr. Robert T. Allison, Jr., Akron; Dr. H. M. Clodfelter, Columbus; Dr. R. Dean Dooley, Dayton; Mr. Clair E. Fultz, Columbus; Dr. Carll S. Mundy, Toledo; Dr. George Sackett, Cleveland; Dr. C. C. Sherburne, Columbus; Mr. Harold W. Slabaugh, Akron; Dr. Edmond K. Yantes, Wilmington; Dr. A. A. Brindley, Toledo; Mr. C. H. Campbell, Columbus; Mr. D. A. Endres, Youngstown; Mr. James B. Fenner, Toledo; Dr. Charles N. Hoyt, Chillicothe; Mr. Edgar W. Jones, Canton; Dr. James S. Mathews, Cincinnati; Mr. Charles

Mills, Marysville; Dr. L. Howard Schriver, Cincinnati; Dr. Robert G. Smith, Circleville; Mr. David L. Temple, Dayton; Dr. Starling C. Yinger, Springfield.

GOITER SURVEY

The Council discussed communications from Dr. John D. Porterfield, Ohio Director of Health, and from Dr. George J. Hamwi, Associate Professor of Medicine and Chief, Division of Endocrinology and Metabolism, Ohio State University College of Medicine. These related to a proposal to resurvey school children in Washington, Butler, Marion and Union Counties to measure the progress which has been made in the past 29 years in the prevention and control of simple goiter. By official action, the Council approved the project, believing that it would be a valuable public health and statistical research activity, and recommended that those making the survey solicit the cooperation and guidance of the county medical societies of the counties surveyed.

The Executive Secretary presented a report on a meeting of the Committee on Interprofessional Relations on Eye Care held in the Columbus office on Sunday, February 28.

NO LIFE INSURANCE PLAN

The Council was advised that the Association would be unable to set up a group life insurance plan for members of the Association, inasmuch as the superintendent of insurance of Ohio ruled on January 25, 1954, that physicians, attorneys and dentists do not qualify for group life insurance as "employees in the same industry" as specified by the group life insurance laws of Ohio.

Communications relating to a project originating in California known as the Audio-Digest Foundation, designed to supply tape recordings on medical lectures to individual physicians who might desire to have them for their office or home, were considered. By official action, The Council authorized that these be filed for future reference.

V. A. QUESTION

The program of the American Medical Association, to inform the profession and the public of the stand of the American Medical Association on that part of the Veterans Administration program providing medical and hospital care for veterans with non-service connected disabilities, was discussed. Doctors Davis and Prugh and Executive Secretary Nelson reported on a regional meeting held in Indianapolis on March 21, under the sponsorship of the American Medical Association.

The Council, by official action, decided that the first step for the Ohio State Medical Association to take in support of this program should be an educational program for members of the medical profession and that this program should be carried on in all parts of the state through county medical societies and regional conferences.

LEGISLATION

The Executive Secretary reported that he and Dr. Frank Mayfield, Cincinnati, chairman of the Committee on Legislation, attended a meeting in New York City on February 13, called by the American Medical Association to discuss pending Federal legislative proposals. He gave a brief review of pending bills and the policy of the American Medical Association, to date, on such proposals.

A report on a conference held in Louisville, Kentucky, on February 24, on Management and Union Sponsored Health Centers was made by the Executive Secretary. This conference was held under the sponsorship of the Committee on Medical Care for Industrial Workers of the Council on Medical Service and Council on Industrial Health of the American Medical Association. Others from Ohio attending the meeting were: Dr. F. F. Rawling, Toledo, Dr. John Budd, Cleveland, and Dr. T. V. Gerlinger, Akron, all of whom were present as official representatives of the Ohio State Medical Association.

WORKMEN'S COMPENSATION

The Council was advised, on behalf of the Committee on Industrial Health and Workmen's Compensation, that the State Industrial Commission is completing its study of proposed changes in the Workmen's Compensation Fee Schedule, submitted a number of months ago to the Commission by the Association. It was stated that the Commission is planning to submit its decision to the Association within the next several days. The Council recommended that a special meeting of the Committee on Industrial Health and Workmen's Compensation be called as soon as possible after word from the Commission is received, for the purpose of reviewing the decision of the Commission and submitting a report to The Council for official action.

The Council was advised that members of the Columbus office staff are attending meetings being held in Columbus by the Ohio Legislative Research Commission and are furnishing testimony when necessary on questions being considered by the Commission which are of direct concern to the medical profession.

RURAL HEALTH

Mr. Page submitted a report on the National Rural Health Conference held in Dallas, Texas, recently. He pointed out that Dr. Carll S. Mundy of Toledo, Vice Chairman of the Council on Rural Health of the A.M.A., played a prominent part in the session and that the session was attended by a number of members of the Committee on Rural Health of the Ohio State Medical Association.

Factual information regarding the national and state investigations of questionable health and

accident insurance companies and their contracts and activities was presented to The Council by the Executive Secretary for the information of The Council.

LABORATORY EVALUATION

A letter to the President from the Chief of Laboratories, Ohio Department of Health, asking for the opinion of the Association on a proposal that the Ohio Department of Health establish a voluntary evaluation plan for clinical pathological laboratories, was read and discussed. Dr. Davis pointed out that he and Dr. L. F. Catron, Akron, had attended a conference last September as representatives of the Ohio State Medical Association at which this question was discussed.

By official action, The Council approved the proposal that the Department of Health sponsor a voluntary evaluation plan for laboratories in order to bring about improvement of laboratory diagnostic procedures of public health significance throughout the state.

TELEPHONE LISTINGS

A communication from the Secretary of a County Medical Society asking for an interpretation of professional ethics involved in the manner in which physicians present information as to their specialty in the telephone directory, was discussed.

By official action, The Council instructed the Executive Secretary to advise the Secretary of the society that in the first instance it is the responsibility of the county medical society to establish a policy on this question, based on local customs and propriety. However, the Council expressed the opinion that it could see nothing unethical or unprofessional in the use of descriptive phrases similar to the following for listings in the classified section of the telephone directory: John Doe, M.D. (name of specialty); John Doe, M.D. (practice limited to diseases of ———, or name of specialty); John Doe, M.D. (specializing in diseases of ———, or name of specialty). It was pointed out that the American Medical directory permits a physician to indicate his specialty, or his inclination toward a specialty, without any proof or designation that he is a member of a specialty society or a diplomate of a specialty board. Several members of The Council stated that should a physician use wording which would imply that he is a specialist and that there was substantial proof showing that the claim is grossly exaggerated, then action by the county medical society would be indicated.

On the question of a telephone listing by a hospital or clinic, The Council by official action expressed the opinion that the Principles of Medical Ethics of the American Medical Association adequately cover the subject—providing that the ethical principles actuating or governing a group or clinic are exactly the same as those applicable to the individual physician and that an institution may use means, approved by the medical profession of its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

REPORTS ON SOCIETIES

Certain cases involving complaints and disciplinary action were reviewed and discussed informally by The Council.

Members of The Council reported on visits to their county medical societies and activities in their counties.

The Council adjourned by a rising vote out of respect to the late Dr. Harold C. Messenger, Xenia, a former member of The Council, and instructed the Executive Secretary to convey to Mrs. Messenger, on behalf of The Council, sincerest sympathy.

Attest: CHARLES S. NELSON,
Executive Secretary

Another Increase in Benefits Is Made By Ohio Medical Indemnity Effective April 1

Another increase in benefits was announced recently by Ohio Medical Indemnity, Inc., Ohio's Blue Shield Plan sponsored by the Ohio State Medical Association.

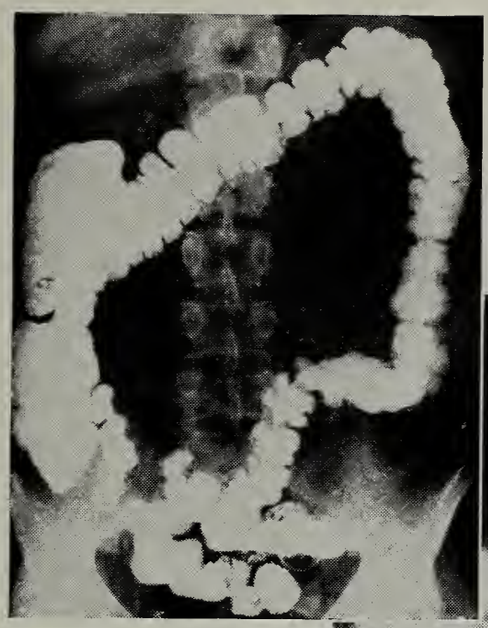
Approximately 1,600,000 persons who are covered by an O.M.I. Standard Contract will benefit without any increase in the subscription fee.

Effective April 1, indemnities will be paid as follows for these procedures (old indemnity shown in parenthesis):

Excision of pilonidal cyst	$ 60.00	($50.00)
Operative cystoscopy	$ 50.00	($35.00)
Repair of cystocele with rectocele	$100.00	($75.00)
Extraction of crystalline lens	$100.00	($75.00)
Fractures:		
Radius & Ulna, simple	$ 50.00	($35.00)
Tibia & Fibula, simple	$ 75.00	($50.00)
Mandible	$ 40.00	($25.00)

Also effective April 1, was an increase in benefits for subscribers covered by the O.M.I. Medical Expense Indemnity Rider. This is the rider covering hospitalized medical (non-surgical) admissions. Coverage has been extended from 30 days to 70 days at no increase in subscription fees. Subscribers will now receive $5.00 per day for the first two days and $3.00 per day for the next 68 days when they are hospitalized with medical illness conditions.

During the year 1953, Ohio Medical paid more than 160,000 claims. It is anticipated in 1954 claims paid will approach 200,000. Many of these patients will receive the increased indemnities.



Normal Colon



Ulcerative Colitis



Atonic Colon

Smoothage and Bulk in Correcting Constipation

To initiate the normal defecation reflex, the "smoothage" and bulk of Metamucil® provide the needed gentle rectal distention.

Once the habit of constipation has been established, due to any of a large number of causes, it becomes a major problem. Self-medication with irritant or chemical laxatives, or repeated enemas, usually causes a decreased, sluggish defecation reflex and may result in its complete loss.

Rectal distention is a vital factor in initiating the normal defecation reflex, and sufficient bulk is thus of obvious importance in restoring this reflex. Metamucil provides this bulk in the form of a smooth, nonirritating, soft, hydrophilic colloid which gently distends the rectum and initiates the desire to evacuate. Metamucil demands extra fluid, imparting even greater smoothage to the intestinal contents.

It is indicated in chronic constipation of various types—including distal colon stasis of the "irritable colon" syndrome, the atonic colon following abdominal operations, repressions of defecation after anorectal surgery and in special conditions such as the management of a permanent ileostomy. Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is supplied in containers of 4, 8 and 16 ounces. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

Reinsurance Proposal . . .

Deemed Unnecessary by House of Delegates of O.S.M.A.; Action Taken At Annual Meeting in Columbus; Subsidy Measures Also Disapproved

PROPOSED Federal legislation to establish a government agency or program for government loans or subsidies to voluntary insurance programs for reinsurance of risks and for loans and subsidies to prepaid plans or medical organizations for facilities and equipment is not needed in the opinion of the House of Delegates of the Ohio State Medical Association.

This action was taken on April 15, 1954, at the 1954 Annual Meeting of the Association in Columbus.

Without a dissenting vote, the House of Delegates adopted the following resolution:

"WHEREAS, One of the major objectives of the medical profession is to promote the best possible health care for all citizens and to assist them in working out sound methods of financing such care, and

"WHEREAS, Tremendous strides have been made through voluntary insurance plans and programs toward providing benefits to millions of Americans for meeting hospital, medical and surgical expenses, and

"WHEREAS, Voluntary insurance organizations and companies throughout the country, with the cooperation and assistance of the medical profession, are engaged in experiments and studies in the area of so-called catastrophic medical expense coverage with a view toward making more and better benefits available to all insurable persons, and

"WHEREAS, There is convincing evidence that the job of making health insurance coverage available to the maximum number of insurable persons can be done through voluntary insurance plans, and private initiative,

"THEREFORE, BE IT RESOLVED, That it is the opinion of the House of Delegates of the Ohio State Medical Association that there is no need for the enactment of legislation for government health insurance, including reinsurance, nor for legislation establishing a government agency or program for government loans or subsidies to voluntary insurance programs, or to prepaid plans or medical organizations, for facilities and equipment.

"AND BE IT FURTHER RESOLVED, That the members, officers and committees of the Ohio State Medical Association shall utilize every legitimate means to bring about the defeat of the following measures now pending in the United States Congress: H.R. 6949, H.R. 8356, S. 3114, H.R. 6950, H.R. 6951 and H.R. 7700; and any similar bills which may be presented to the Congress."

It is recommended that physicians concurring in the action taken by the House of Delegates write their Congressman and Senators Bricker and Burke promptly as the measures referred to in the resolution are now being heard in both the Senate and the House.

A.M.A. POSITION

Similar action has been taken by the American Medical Association. Following are excerpts from testimony presented to the Congress by Dr. David B. Allman, a member of the Board of Trustees of the A.M.A., speaking on behalf of the A.M.A.

"I should like to state at the outset that the American Medical Association is in complete accord with the principal purpose of the bill, which is to promote the best possible medical care on reasonable terms. It is reassuring to the medical profession to find that the official position of the government is one of trust and confidence in the ability of private initiative to solve existing problems in the field of medical care. As was stated before this Committee last January, our Association has for many years adhered to a policy which parallels the above referred to purpose of this bill. We are also in agreement that the most feasible method of accomplishing this result for most of the people is through voluntary health insurance.

"The Association, however, seriously doubts whether the mechanism suggested in H.R. 8356 is essential and whether it will, in fact, accomplish the desired results.

VOLUNTARY SYSTEMS

"In determining its essentiality we believe that it is necessary to give full and complete consideration to the tremendous strides which voluntary health insurance has made in this country and the simultaneous improvement in benefits provided to meet the desire of the public for more adequate protection. The expansion of coverage and the improvement of benefits to cushion the economic shock of hospital, surgical and medical expenses, has been phenomenal during the past few years. Inasmuch as complete statistical data outlining this expansion and

growth have been made available to your Committee by previous witnesses, I shall not repeat these figures at this time. I understand you have also been briefed on the progress and prospects of the newest area of health insurance —'major medical expense' coverage which is designed to provide protection against the unpredictable, the unexpected, illness, acute or chronic, the financial impact of which would seriously disrupt the family budget.

"It is our belief that the figures which have been presented hold real promise for still greater progress in health insurance coverage. This fact plus the demonstrated ability of the industry to meet the needs and demands of the public indicates to us that it is unnecessary for the federal government to enter the field. The public interest will be served best and continued progress of health insurance protected by preserving the freedom and competitive features of the present method of operation.

NO MAGIC TOUCH

"We were impressed by the comments of Mr. Edwin J. Faulkner when he said, in testifying before your Committee on March 26:

> "'Government reinsurance of health insurance plans would introduce no magic into the field of financing health care costs. Reinsurance can distribute risks among insurers just as insurance distributes them among policy-holders, but no matter how far this distribution is carried, it must be sound to succeed. Reinsurance does not increase the ability of the insurer to sell protection to the unwilling buyer. Reinsurance does not reduce the cost of insurance. Reinsurance does not make insurance available to any class of risk or geographic area not now within the capabilities of voluntary insurers to reach.'

DOES NOT ENHANCE POWER OF INSURANCE

"Another statement by Mr. John H. Miller on behalf of three Health and Accident Insurance Associations with over 300 member companies stated, in part:

> "'Reinsurance, therefore, does not provide a means of making insurable what would otherwise be an uninsurable risk. It does not add to the aggregate resources of the insurers. It does not help to sell insurance nor does it reduce the cost of insurance. If our citizens are not to labor under a misunderstanding, it is essential for them to realize that reinsurance is not a panacea, and that it does not provide additional funds to finance the cost of medical care. As has been made clear in the presentation of the program, voluntary insurance cannot relieve the community of the burden of providing medical care to the indigent nor is it helpful to those who presently cannot qualify for it, and reinsurance does not enhance the power of insurance in these areas. The reinsurance facilities have been proposed with the purpose of extending the frontiers of insurance effectiveness. The rapid development of accident and sickness insurance has, however, been accomplished with little use of the already extensive reinsurance facilities available to the insurers, and we see no evidence that progress would have been augmented had reinsurance been used to a greater extent. The underwriting, or risk bearing, capacity of the companies in this business is very large.'

"These and other expressions of opinions from the insurance industry plus our analysis of the bill have led us to the conclusion that a federal reinsurance system such as proposed by the bill could not be expected to achieve the objectives set forth in this legislation. In addition, the measure as drawn would place extensive regulatory power in the Secretary of the Department of Health, Education and Welfare. The concentration and delegation of such potential power and control over a vital branch of American industry in a department of the Executive Branch of the government without clear and convincing evidence of need is extremely difficult to justify.

"Let me reiterate that we believe the sponsors of this proposal are deserving of commendation in attempting to spread voluntary health insurance through private initiative. Nevertheless it is the belief of the American Medical Association that the bill will not fulfill its intended purpose and may, in fact, inhibit the satisfactory progress which is now being made by voluntary insurance companies. For these reasons it is the recommendation of the Association that this bill should not be reported favorably by this Committee."

Get-Together for Ohio State Alumni To Be Held in San Francisco

Dr. Carl A. Lincke, president of the Medical Alumni Association of Ohio State University, announced that there will be a dinner for all Ohio State doctors in San Francisco in connection with the American Medical Association meeting.

The affair will be held in the Vanderbilt Room of the Fairmont Hotel at 7 p.m., preceded by cocktails. Victor H. Holliger, M.D., '44, Stonestown Medical Building, San Francisco, is local chairman of the affair and is arranging the details. Dr. Holliger is also president of the San Francisco Alumni Club of O.S.U.

The dinner will be priced at $5 plus tax and wives and/or husbands are invited. Reservations should be sent to Carl A. Lincke, M.D., president Medical Alumni, 24 Second St., N.E., Carrollton, Ohio.

Six Wee



If you haven't met the Breon man, you should. We're sure you'll find his Regular Service a friendly, pleasant way of doing business. Things seem to "fall into place" when he calls. You know when he is coming. You know when he'll be back. Your medicine cabinet stays filled with just the right amount of those items you need. Costly overstocking disappears. And don't worry about "not having enough." Breon's Regular Service will keep you well-supplied with up-to-date, reasonably-priced pharmaceuticals. Let the Breon man show you what we mean. Just send this ad with your name and address to Geo. A. Breon & Co., 1450 Broadway, New York 18, N.Y.

BREON

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Resume Military Calls . . .

Military Advisory Committees Alerted as Selective Service Directs Boards To Begin Processing; Call Comes Earlier Than Anticipated

BECAUSE of unforeseen shortage of physicians in service, the Selective Service will resume processing of physicians in certain categories earlier than had been previously anticipated, according to an announcement from Dr. Drew L. Davies, chairman of the Ohio Advisory Committee to Selective Service and chairman of the Ohio State Medical Association's Military Advisory Committee.

Dr. Davies' announcement was based on Operations Bulletin No. 109, issued by the National Headquarters Selective Service System, Washington, D. C., which is as follows:

OFFICIAL BULLETIN

SUBJECT: Processing of special registrants for Armed Forces physical examination and for induction and review and reopening of the classifications of certain special and regular registrants in Class II-A.

1. This Headquarters is advised that the Armed Forces expect to levy a call for physicians on the Selective Service System in the near future. Calls for dentists to be delivered in March, April and May of 1954 have already been allocated to the States.

2. Local boards are requested to resume the processing for armed forces physical examination and for induction of Priority I and II physicians of all ages, Priority III physicians born after August 30, 1922, and Priority I, II, and III dentists of all ages.

3. Local boards are also requested to review the classifications of physicians and dentists of the priorities and ages referred to in paragraph 2 of this Operations Bulletin and to reopen and consider anew the classifications of those special registrants in Class II-A whose classifications will expire prior to August 1, 1954.

4. (a) Local boards are further requested to reopen and consider anew the classifications of all regular registrants who are physicians and dentists presently classified in Class II-A whose classifications will expire prior to August 1, 1954, keeping in mind that the requirements of the Armed Forces for physicians and dentists should be met as far as possible with regular registrants.

(b) The provisions of Operations Bulletin No. 88, as amended, should be implemented promptly with respect to physicians and dentists classified in Class I-A as regular registrants.

5. Operations Bulletin No. 102, issued on September 22, 1953, is rescinded.

(Signed) Lewis B. Hershey, Director.

(Operations Bulletin No. 102, referred to in the foregoing paragraph, basing its prediction on the outlook at the time it was issued, indicated that there would be no more calls for physicians at least through fiscal 1954, or through June 30, 1954.

COOPERATION REQUESTED

In informing County Military Advisory Committees of the new development, Dr. Davies called attention to an information release from the National Advisory Committee to Selective Service which reads as follows:

SUBJECT: Attached Selective Service Operations Bulletin No. 109 Concerning the Resumption of Processing of Special Registrants.

Attached hereto is Operations Bulletin No. 109 which requests all local boards to resume processing for Armed Forces physical examination and for induction, Priority I and II physicians and dentists of all ages, Priority III dentists of all ages and Priority III physicians born after August 30, 1922.

Your wholehearted cooperation with local boards will be greatly appreciated.

Session on Legal Medicine at San Francisco Meeting

The growing importance of medicolegal issues has been recognized by scheduling of a session on legal medicine at the American Medical Association Session in San Francisco. The program, under direction of the A.M.A.'s Committee on Medicolegal Problems will be held on Thursday, June 24, in the White Room of Masonic Temple, 25 Van Ness Avenue, 9:00 a.m. to noon.

The following program has been announced:

"Advice to the Medical Witness," W. I. Gilbert, president of the Los Angeles Bar Association.

"Malpractice, an Occupational Hazard," Dr. Louis J. Regan, Los Angeles, vice-chairman of the A.M.A. Committee on Medicolegal Problems.

"Medicolegal Problems Related to Sterilization, Artificial Insemination and Abortion," J. W. Holloway, Jr., Chicago, secretary of the A.M.A. committee, and Edwin J. Holman.

"Prevention of Transfusion Accidents," Dr. Alexander S. Wiener, Brooklyn, also a member of the committee.

"Legal Aspects of Medical Partnerships," George E. Hall.

"Trauma, Stress and Coronary Thrombosis," Dr. Alan R. Moritz, Cleveland, chairman of the A.M.A. Committee on Medicolegal Problems.

Mental Health . . .

Governor Lausche and Other Governors at National Conference Set Up Proposed Standards for State's Responsibility in 10-Point Program

AN EFFORT toward establishing common standards in state-sponsored mental health programs was made at the first National Governors' Conference on Mental Health, which was held in Detroit, February 8 and 9.

Governor Frank J. Lausche and other governors who attended the conference agreed upon and signed a 10-point program on mental health, which reviews some of the shortcomings of programs and makes recommendations for their improvement.

It is particularly appropriate that these proposed standards be called to the attention of physicians since the week of May 2-8 has been designated as National Mental Hygiene Week.

The 10-Point program on Mental Health is as follows:

CARE AND TREATMENT

1. By far the major share of a State's mental health resources must be used for the care and treatment of patients in State hospitals for the mentally ill. Psychiatric treatment with the fullest use of existing knowledge can return many more people to productive and useful lives.

Increased appropriations for additional qualified mental health personnel (including psychiatrists, psychologists, social workers, nurses, and related personnel) and intensive treatment programs should be provided by the States at their next legislative sessions to increase the number of patients discharged from State mental hospitals.

TRAINING AND RESEARCH

2. Training and research in the field of mental health are essential elements of effective mental health programs. The serious accumulation of patients and costs can only be reduced by discovering new knowledge and new methods of treatment and by more adequate training and development of mental health personnel.

State legislatures are urged to appropriate specific sums for training and research in addition to the regular appropriations for care and treatment.

PREVENTIVE METHODS

3. Ultimate reduction of the population in State mental hospitals can only be achieved by efforts to prevent mental illness. This requires facilities for early identification, for early treatment and for aftercare and supervision of those on leave from State hospitals.

State governments should take the initiative with both financial and professional assistance in stimulating local public and private agencies to participate actively in preventive programs.

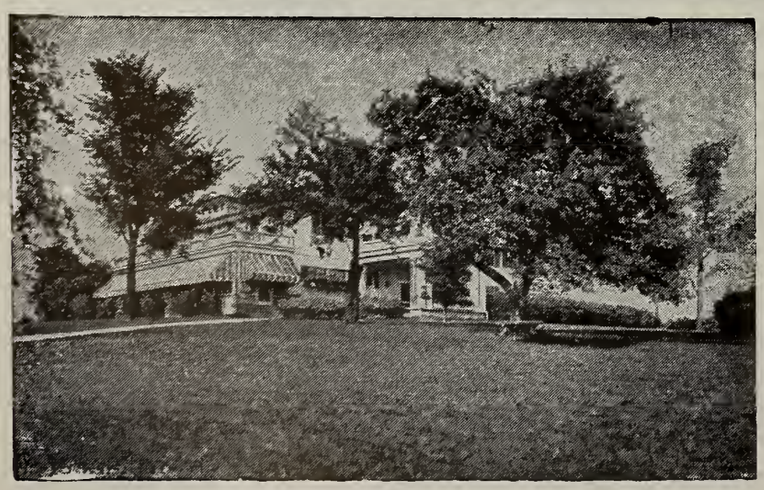
BASIC AND APPLIED RESEARCH

4. At present it is estimated that less than one per cent of total State mental health budgets is expended for research—$4 million out of a total expenditure of about $560 million.

Based on a comprehensive survey of State mental health officials, it is recommended that the States should devote a much larger percentage of their total mental health budgets to basic and applied research in the biological and behavioral sciences and to the training of personnel in research methods.

ORGANIZATION

5. Effective training and research programs cannot be achieved without effective organization. A position of director of training and research should be established within the mental health agency in each State to assume responsi-



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bility for the coordination of mental health training and research within the State's jurisdiction.

A technical advisory committee, composed of scientists and educators in the field of mental health, cooperating with scientists in universities and industry, should be established in each State to advise and assist the mental health agency and other State departments concerned with the coordination of training and research activities.

RESIDENCY PROGRAMS

6. State institutions which are not accredited for residency or as affiliate training centers for psychiatrists, clinical psychologists, social workers, nurses, and other professional groups should receive support from governors and legislatures in their endeavors to raise the level of teaching and supervision in their institutions to secure accreditation.

STIPENDS

7. The States should provide stipends for graduate training in the psychiatric field, should adjust salary scales, and should provide educational leaves of absence so that State mental hospitals may compete effectively for the limited personnel available to fill treatment, teaching, and research positions.

UNIFORM TERMINOLOGY

8. One of the important obstacles to adequate evaluation of procedures and therapies is a lack of uniformity in statistical methods in mental hospitals and clinics throughout the country. All States should cooperate with the United States Public Health Service and the American Psychiatric Association in the adoption of uniform terminology for statistical reporting procedures in the field of mental health.

CONFERENCES

9. Joint action by groups of States may provide one of the most fruitful means of attacking mental illness. This can be partially achieved by periodic regional mental health conferences, regional programs such as that now sponsored by the Southern Regional Education Board, and by active participation in the Interstate Clearinghouse now established through the Council of State Governments by request of the Governors' Conference.

The clearinghouse, in cooperation with existing public and private agencies, will provide a medium for exchange of pertinent information among the States, will assist the States in organizing more effective mental health programs, and will help in developing interstate agreements so that groups of States can utilize to the fullest extent existing training and research facilities.

COMMUNITY PARTICIPATION

10. State and community mental health organizations should play important roles in educating the public to the problems of mental health and to the methods of improving psychiatric services.

The States should encourage and support mental health education in the schools, good relationships between hospitals and their surrounding communities, and the provision of adequate community psychiatric services. These may, in the long run, be most important in determining the mental health of the Nation.

(Signed by) Govs. C. Elmer Anderson, *Minnesota;* Edward F. Arn, *Kansas;* Frank G. Clement, *Tennessee;* George N. Craig, *Indiana;* Frank J. Lausche, *Ohio;* William C. Marland, *West Virginia;* Robert B. Meyner, *New Jersey;* Johnston Murray, *Oklahoma;* William G. Stratton, *Illinois;* G. Mennen Williams, *Michigan.*

Columbus Cancer Clinic Facilities Will Move to O.S.U. Campus

All operations and services of the 33-year-old Columbus Cancer Clinic, now located at 221 E. State Street in Columbus, will be moved to the cancer wing of the Ohio State University Medical Center, effective September 30. Announcement was made following a meeting of the cancer clinic board on March 29.

The move was made "with the clear understanding that the clinic and all its facilities and services remain under the control of the board of directors of the Columbus Cancer Clinic." Special clinics of the Columbus Cancer Clinic have been in operation for about a year at the O.S.U. Medical Center. The new cancer wing at the Center was officially put into use in May, 1953, with dedication ceremonies.

Medical director and assistant medical director, respectively, of the Columbus Cancer Clinic are Dr. Charles A. Doan, dean of the O.S.U. College of Medicine, and Dr. Arthur James.

Cincinnatian Is Named on World Industrial Health Committee

Dr. Robert A. Kehoe, Cincinnati, has been named on an 11-member committee to advise the World Medical Association on formation of an international occupational health program.

The World Medical Association, representing 700,000 physicians in 46 national medical associations, announced that plans are underway to establish an International Committee on Occupational Health Services for the benefit of industrial workers everywhere.

At an initial meeting in New York recently, more than 35 industrial health leaders in the United States explored the feasibility of embarking on an international occupational health program and urged the World Medical Association to take it over.

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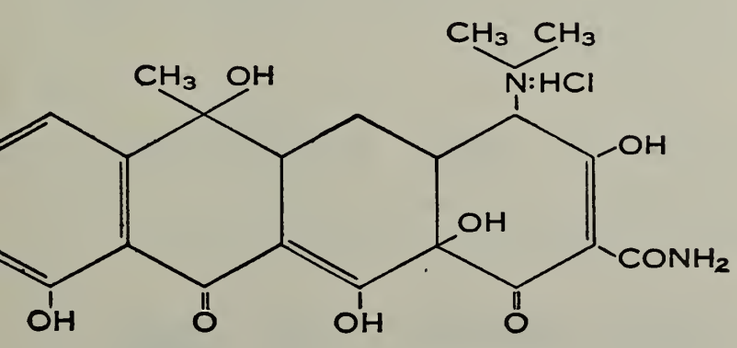
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Narcotic License Must Be Renewed By July 1 to Avoid Penalty

On or before July 1 every physician registered under the Harrison Narcotic Act, must, unless he is in military service, reregister with the Director of Internal Revenue of the district in which he maintains an office, and pay the Federal Narcotic Tax of $1.00. Initial application may be made at any time, but existing permits must be renewed on or before July 1, annually.

Federal officials reported that last year a number of physicians failed to reregister within the allotted time. Failure to reregister by July 1 adds a penalty to the annual tax and, in addition, makes the physician liable to a fine not to exceed $2,000 or to imprisonment for not more than five years, or both.

Copies of Form 678, application for reregistration, are scheduled to be mailed about June 1 by the District Director of Internal Revenue to each Ohio physician already registered, with brief instructions of the procedure to be followed.

The physician must note on his application the number of his license to practice medicine in Ohio. The registration number assigned by the Department of Internal Revenue is retained from year to year. In the case of a partnership, each partner must sign the application. **Remittance accompanying the application may be in the form of cash, a postal money order, or certified check. Personal checks not certified will be returned to senders.**

Form 678 contains space on the reverse side for an inventory. The duplicate copy is to be retained by the registrant. Only the signature of the registrant is required on the form since it contains a declaration in lieu of a jurat.

Inventories may be taken at any time after the receipt of the application forms each year, and may be filed as soon as completed. They must be filed by July 1.

Physicians who administer, dispense, or prescribe cannabis, must obtain a special permit under the Marihuana Tax Act, and reregister annually on or before July 1, with the Director of Internal Revenue of his district, and pay a tax of $1.00 in addition to the regular registration fee.

A physician in the armed forces need not reregister. If such a physician should receive an application form for reregistration he should return it to the office of the Director of Internal Revenue from which it was sent, together with a statement that he is in the armed forces, that he does not have in his possession any narcotics, and requesting that the registration number previously assigned to him be reserved.

Upon his return to civilian practice, a physician who has been in military service must immediately apply for registration. He will be assigned his former registration number.

Don't Worry—Your A.M.A. Card Is On the Way

Word from the Membership Department of the A.M.A., Chicago, is that 1954 membership cards are being mailed out daily in big lots to physicians who have paid 1954 A.M.A. dues.

If you haven't received yours by now, you will get it quite soon.

Physicians planning to go to the 1954 A.M.A. meeting in San Francisco should not worry—their card will reach them in plenty of time.

Opportunities Are Available in Ohio As Health Commissioners

There are a number of opportunities in Ohio for physician health commissioners, according to an announcement from the Ohio Department of Health. In some instances a choice of location is available. The policy of the Ohio Department of Health permits further academic training of physicians who wish to make a career of public health or prepare themselves for membership in the American Board of Preventive Medicine.

Interested physicians are invited to communicate with the Ohio Department of Health, Bureau of Local Services, 306 Ohio Departments Building, Columbus 15.



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ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL FOR YEAR ENDING DECEMBER 31, 1953, BY KELLER, KIRSCHNER, MARTIN & CLINGER, CERTIFIED PUBLIC ACCOUNTANTS, COLUMBUS, OHIO

OHIO STATE MEDICAL ASSOCIATION

Cash and Bonds on Hand, January 1, 1953:		
Cash in Huntington National Bank		$ 8,260.52
Cash in Ohio National Bank (dues paid in advance)		47,475.00
U. S. Treasury and Savings Bonds		80,000.00
Total Cash and Bonds on Hand, January 1, 1953		$135,735.52
RECEIPTS		
Interest on U. S. Treasury and Savings Bonds	$ 2,000.00	
1953 Membership dues collected in 1953	105,790.00	
1954 Membership dues collected in 1953	63,760.00	
1953 Exhibit space collected in 1953	8,627.50	
1954 Exhibit space collected in 1953	4,802.00	
Banquet tickets sold, Annual Meeting	2,522.00	
Payment for collection of American Medical Assn. dues	1,714.35	
L. Thompson Check cancelled	2.00	
Cleveland Academy Dues Payment	15.00	
Total Receipts		$189,232.85
Total To Be Accounted For (Includes 1954 Dues and 1954 Exhibit Payments, Collected in Advance)		**$324,968.37**
DISBURSEMENTS		
Ohio State Medical Journal	$ 27,000.00	
Executive Secretary, salary	12,260.00	
Executive Secretary, expense	1,614.02	
President, expense	248.50	
Stenographic and clerical personnel, salaries	22,671.68	
Council, expense	2,689.66	
A.M.A. Delegates, expense	2,766.19	
Conference of County Society Presidents and Secretaries	1,172.63	
Dept. of Public Relations:		
Director, salary	$10,520.00	
Director, expense	1,280.35	
Asst. Director, salary	6,100.00	
Asst. Director, expense	1,488.53	
Exhibits and newspaper publicity	1,071.57	
Literature	3,252.94	
Postage	1,045.03	
Supplies	108.61	
Miscellaneous expense	2,926.40	
		27,793.43
Standing Committees:		
Education	$ 175.00	
Public Relations and Economics	379.44	
Scientific Work	402.19	
		956.63
Special Committees:		
Auditing and Appropriations	$ 430.00	
Industrial Health	1,980.71	
Medical Care of Veterans	177.00	
Military Advisory Chairman, salary	66.79 4,500.00	
Rural Health	893.22	
School Health	383.34	
		8,431.06
Annual Meeting		18,031.78
Employees, bonus		1,727.03
Insurance, bonding, social security		2,511.12
Legal expense		1,102.06
Postage		1,010.00
Professional Relations Activity (OSMAgram and miscellaneous)		5,578.92
Rent		7,349.52
Retirement Fund		3,652.45
Rural Medical Scholarships		2,000.00
Stationery, printing, supplies		2,670.96
Telephone and telegraph		2,050.99
Refunds: Banquet tickets, exhibit space, dues		204.50
Total Disbursements		$155,493.13
Cash on Deposit and Bonds on Hand, December 31, 1953:		
Huntington National Bank	$ 25,715.24	
Ohio National Bank (dues paid in advance)	63,760.00	
U. S. Treasury and Savings Bonds	80,000.00	
Total Cash and Bonds on Hand, Dec. 31, 1953		$169,475.24
Total Accounted For (Includes 1954 Dues and 1954 Exhibit Payments, Collected in Advance)		**$324,968.37**

THE OHIO STATE MEDICAL JOURNAL

ASSETS

Current Assets:		
Cash in Ohio National Bank		$ 3,063.67
Petty cash		20.00
Total Cash		$ 3,083.67
Accounts receivable: Advertisers	$2,387.12	
Postage deposit	100.00	
		2,487.12
Total current assets		$ 5,570.79
Property Assets:		
Furniture and equipment (depreciated value)		$ 11,606.16
Total Assets		**$ 17,176.95**

LIABILITIES AND SURPLUS

Surplus, December 31, 1952	$ 16,318.95	
Net income for year ended December 31, 1953	851.00	
Total Surplus, December 31, 1953		$ 17,169.95

STATEMENT OF PROFIT AND LOSS

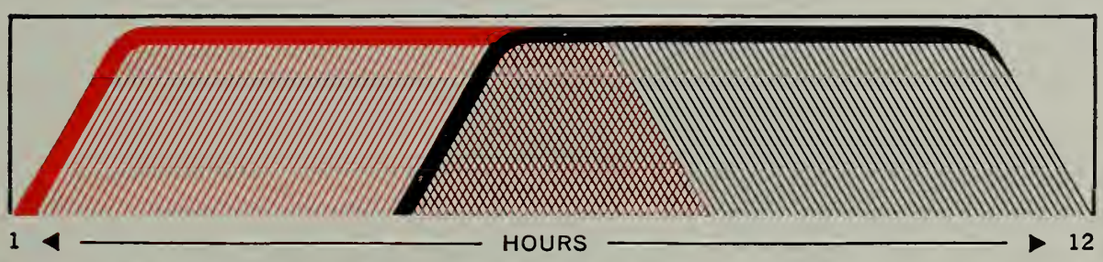
Income:		
Advertising, gross		$ 34,121.19
Less:		
Commission on advertising	$ 2,657.93	
Discount on advertising	957.91	
		3,615.84
Advertising income, net		$ 30,505.35
Ohio State Medical Association, appropriation		27,000.00
Subscriptions and sales		689.45
Miscellaneous Receipts: Postage advanced and repaid		21.77
Total Income, net		$ 58,216.57
Expenses:		
Journal printing	$ 40,163.85	
Salaries	11,829.56	
Journal postage	793.90	
Illustrations and engravings	339.30	
Travel expense	35.20	
Office supplies and expense	2,498.89	
Auditing	140.00	
Miscellaneous expense	168.00	
Miscellaneous postage	158.78	
Depreciation	1,229.09	
Uncollectible accounts (advertising)	9.00	
Total expenditures		$ 57,365.57
Surplus for the year		$ 851.00

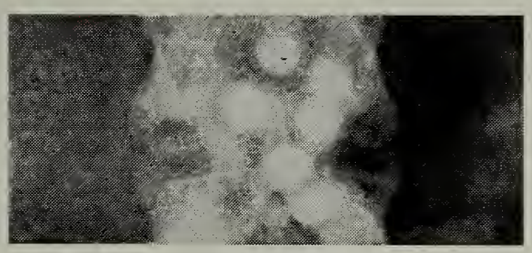
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SCHERING

Older Workers . . .

Many Physicians Can Play a Vital Role in Helping Them To Solve Their Economic, Social Problems, as Well as Medical Problems, Writer States

EVERY physician in these times should devote some of his energy and brains to the task of trying to find answers for the social and economic, as well as the medical, problems which confront the aging people of his community. The physician engaged in industrial medicine, or one who sees in his daily practice older workers, has a great opportunity to take an important role in this big community-wide and nation-wide program.

Some important facts and pertinent observations on this question were made in a recent article published in the Hennepin County (Minneapolis) Medical Society Bulletin. It was written by Dr. W. E. Park industrial health physician Minneapolis Health Department and read as follows:

* * *

MOST people who are concerned with sociological matters realize that one of the pressing problems of our day is what to do with older people who are still energetic and not totally disabled.

Several factors have contributed to the present situation. There has been a shift in age distribution so that our population contains many more people over sixty-five years of age than formerly. This is true both in total numbers and in percentage. In 1900, there were about three million in the United States over sixty-five years of age. In 1950, there were eleven and a half million. In 1900, the proportion was one in twenty-five. Now it is one in eight.

One of the causes of the increase in numbers is the success of medical and related sciences in increasing the average life expectancy by about fifteen years. Another feature, which makes the problem more acute, is the shift of population from the predominantly agricultural activities at the turn of the century to the present concentration in urban areas. Agriculture has always been more able to use elderly people than industry. Even now, agriculture is using 65-year-olds and up in its labor force, to the extent of 13 per cent, as compared to 5 per cent in American industry.

AN IDEAL SHATTERED

The thinking of 10 or 15 years ago was that it would be a fine thing to retire at about sixty-five years of age and enjoy the last years of life in leisure. To this end, many companies instituted pension and retirement plans, and the Government put Social Security into effect.

Several unforeseen factors have combined to shatter that dream of ease and happiness in old age. First, inflation and the increased cost of living have made the funds set aside inadequate.

Secondly, unforeseen numbers of people at 65 years of age are too vigorous and healthy to be happy in the stagnant shallows of life.

Thirdly, the burden of this unproductive element in the population is becoming too great for the working population to carry. It is estimated that the loss in actual output caused by premature retirement of able but aged workers costs the nation in excess of five billion dollars a year. When the costs of private pension plans and government programs are added to this figure, the loss represented by retiring workers at 65 is staggering.

HOLD-THE-LINE FACTORS

There are three important factors which tend to perpetuate and aggravate the situation. First, companies with old-age benefit plans frequently rigidly enforce retirement at the chronological age of 65 regardless of capacity to work.

Secondly, labor unions' insistence on seniority rights and non-declining wage scales makes job adjustment and tapering off so difficult that employers are frequently unable to retain an older worker who is slowing up.

Thirdly, the reluctance of both management and industrial physicians to appraise fairly the productive capacity of an applicant when faced with an age label of over forty.

RESOURCES OF OLDER AGE GROUP

Before an industrial physician can introduce and operate an effective plan to salvage and use the resources and energies of the older age group, both he and the management of the company he serves must be convinced of the value of the older worker.

It is admitted that aging brings about a decrease in speed, agility, and strength. However, these are replaced by compensating factors such as increased skill, better judgment, pride in work, loyalty to the company, and a more tolerant attitude. These virtues are reflected in better quality of work, fewer accidents, less absenteeism, and better industrial relations.

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Niacin—5 milligrams
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ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Dodge Division of Chrysler Corporation some years ago showed that a group of old men and handicapped workers rated near the top, with production rejects of less than one per cent as compared with two per cent in most other departments. Franco mentions a Bureau of Labor Statistics survey which shows that absenteeism of workers 65 to 69 years of age is only 3.3 days per 100, while the rate for workers 25 to 29 years old is 4.3 days per 100. An older worker will take longer to recover after a specific injury, but this is more than compensated for by his fewer accidents.

RESPONSIBILITY OF PHYSICIAN

The responsibility of the industrial physician lies in two directions: to further the employment of older people in industry and to maintain the productive capacity of older workmen at the highest possible level.

The industrial physician can very materially mold the attitude of management to employment of older more experienced workmen. He can insist that physiological health and physical and mental capacity are far more important than chronological age. He can influence the placement of older workmen in positions which they can fill effectively without undue stress.

It is usually unwise to place an older workman on a production line where the speed is determined by younger men. His skills are more valuable in precision work or in teaching.

The industrial physician should not be involved in any dispute between labor and management over a workman's seniority rights but he should know, and state clearly, a man's ability to perform a job satisfactorily from the standpoint of muscle strength, endurance, physiological function, and mental stress. His opinion should be based upon his careful physical examination and over-all appraisal of the whole man without undue regard for his chronological age and economic status.

In an effort to keep older workers employed and at a high level of productive capacity, the industrial physician has an excellent opportunity to practice prophylactic geriatrics. He must appreciate the types of diseases which afflict older people.

A WATCHFUL EYE ON AGE

The high incidence of cardiovascular diseases and cancer among older workmen is a prominent feature. Other chronic diseases such as arthritis and those due to tissue hypofunction or degeneration assume a prominent role. Emotional disturbances due to slowing of physiological functions, piling up of domestic or economic difficulties, and the realization of declining capacity to cope with them all complicate the picture.

The efforts of the industrial physician should be directed toward minimizing and meeting sanely the inevitable ravages of the aging process.

The frequency of physical examinations should be stepped up after 40 years of age. In the more advanced age group, it may be indicated every six months. In examining an older workman, the physician will tend to make more use of laboratory investigations to determine physiological function. He will be more concerned with hypertension and other evidence of stress. He will want to know something about the rate of oxygen consumption and thyroid activity and the balance of function in other endocrine glands.

Much can be gained for the older worker by seeing that he gets well-fitted dentures, maximum correction of visual defects, and hearing aids when needed.

The older worker particularly needs constant attention to his diet. The industrial physician and nurse can give much guidance in nutrition. His diet should contain sufficient protein (1.2 gm. per kilo of body weight), fat up to 80 gm. per day, liberal supplies of vegetables and fruits, and sufficient amounts of minerals and vitamins.

The interest of the medical staff extends to the home life of aging employees. Much can be done to brighten their lives by organization of recreational and hobby groups, for the older workman too must have a full and satisfying life to be in maximum health.

In the plant much of the dread of retirement can be forstalled by training classes which prepare the workman psychologically and seek to interest him in new fields of leisure activity.

The industrial physician, management, and labor can and should work together toward a saner system of retirement which gives each workman individual consideration and permits maximum utilization of his waning strength instead of arbitrary termination of employment at a stimulate age.

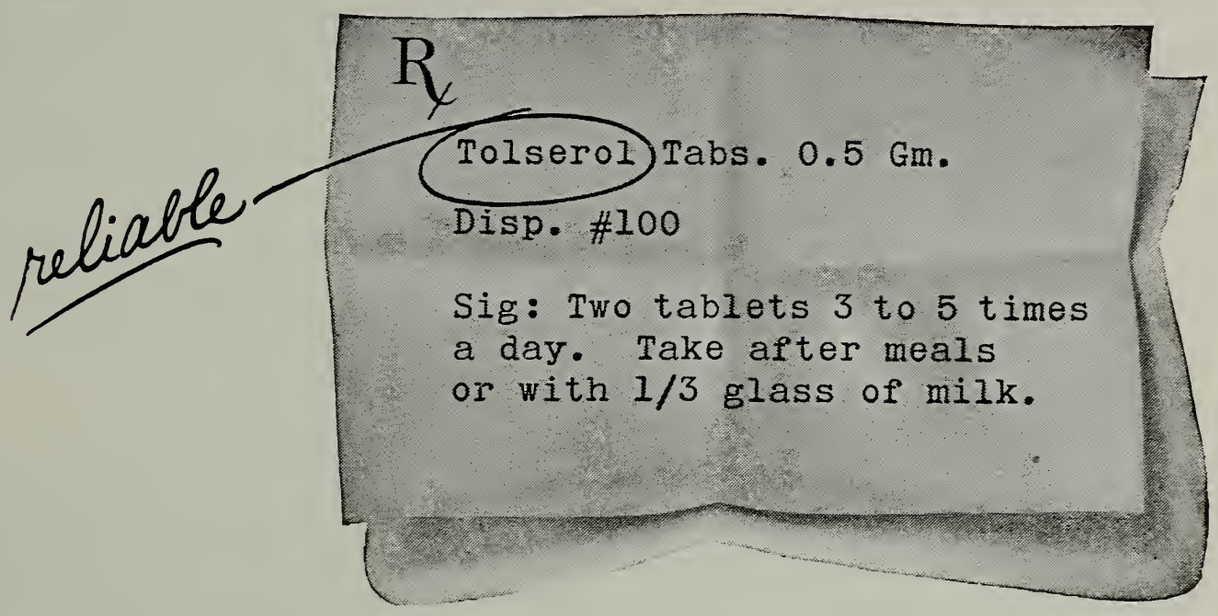
Last Call For Those Wanting To Join Special Train Party

This is the last call for Ohio physicians who may be thinking about joining the Ohio State Medical Association Special Train Party to the West in June when the A.M.A. will meet in San Francisco. The Ohio Special will leave Chicago on June 12.

Space on the Ohio Special still is available. Also, hotel rooms are available for those in the party.

Anyone interested should get in touch immediately with Executive Secretary Charles S. Nelson of the Columbus Office for complete details, application blank, etc.

RAPID ABSORPTION—*MAXIMUM THERAPEUTIC EFFECT*



The clinical effectiveness of different brands of mephenesin tablets depends on their rate of absorption. A mephenesin tablet that disintegrates slowly is absorbed slowly. The resulting low blood levels may never produce a maximum therapeutic effect. Results with such a tablet are usually poor.

Tolserol Tablets are a result of extensive study and are formulated to disintegrate rapidly for fast absorption, thus maintaining optimum blood levels.

Tolserol

(*Squibb Mephenesin*)

Complete information on the use of Tolserol in muscle spasm of rheumatic disorders, in neurologic disorders and in acute alcoholism is available from the Professional Service Department, Squibb, 745 Fifth Avenue, New York 22, N. Y.

SQUIBB

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

RELATIONS WITH PRESS, RADIO AND TELEVISION

One part of the public relations program of the medical profession is to encourage physicians to play a more active role in civic and community activities—speaking engagements, conferences, etc.

Another is to bring about a closer working relationship between physicians, medical societies and all media of public communication—press, radio and television.

Therefore, it is important that physicians have a thorough understanding of what the Principles of Medical Ethics have to say on this question so they can speak or be quoted and still be within the bounds of professional ethics and propriety.

As recently revised by the House of Delegates of the American Medical Association the Principles of Medical Ethics contain the following advice on the relationship of the physician to media of public information:

"Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not always easily accessible or readily understandable.

"The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. On the other hand, it may often happen that the representatives of popular news media are the first to perceive the adaptability of medical material for presentation to the public. In such a situation the physician may be asked to release to the public some information, exhibit, drawing or photograph. Refusal to release this material may be considered a refusal to perform a public service, yet compliance may bring the charge of self-seeking or solicitation.

"An ethical physician may provide appropriate information regarding important medical and public health matters which have been discussed during open medical meetings or in technical papers which have been published, and he may reveal information regarding a patient's physical condition if the patient gives his permission, but he should seek the guidance of appropriate officials and designated spokesmen of component or constituent medical societies. Spokesmen should be empowered to give prompt and authoritative replies and a list should be issued which identifies them and discloses the manner in which they may be reached. These provisions are made with full knowledge that the primary responsibility of the physician is the welfare of his patient but proper observation of these ethical provisions by the physician concerned should protect him from any charge of self-aggrandizement.

"Scientific articles written concerning hospitals, clinics or laboratories which portray clinical facts and technics and which display appropriate illustrations may well have the commendable effect of inspiring public confidence in the procedure described. Articles should be prepared authoritatively and should utilize information supplied by the physician or physicians in charge with the sanction of appropriate associates.

"When any sort of medical information is released to the public, the promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

"An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated."

JUDGMENT OF JOURNAL ON KENT ADS SUBSTANTIATED

About six months ago, *The Journal*, with approval of The Council, refused to publish a series of advertisements for Kent Cigarets, because the ads made certain health and medical claims.

Time has proved that the judgment of *The Journal* management and The Council was sound. Attest: The following editorial published in the April 3 issue of *The Journal of the American Medical Association*:

"The unauthorized and medically unethical use of the prestige and reputation of the American Medical Association and *The Journal* (of the A.M.A.) in Kent cigarette advertisements currently appearing in the American press and other channels of mass communication constitutes an outrageous example of commercial exploitation of the American medical profession. The implication in these advertisements that the American Medical Association authorizes, supports, or approves any particular brand of cigarettes or combination of claims made in their behalf—whether pygmy-sized or king-sized, with or without filters, nicotinized or denicotinized—provides a most reprehensible instance of hucksterism. The manner in which the P. Lorillard Company has extolled its particular brand of cigarettes by reference in its advertisements to the American Medical Association and *The Journal* (of the A.M.A.) is to be strongly condemned.

"On the basis of only one factor isolated from many, the P. Lorillard Company blatantly implies that the efficiency of their brand of filter tip solves the health problems associated with cigarette smoking. This approach to a vital problem is ill-conceived and lacks factual medical support. The inference that any type of filter has the approval of the American Medical Association is equally without foundation. Until the clinical relationship between the amount of nicotine and tars and their effect on the individual smoker is conclusively established, no filter can offer a panacea except one that possesses 100 per cent efficiency. The hard facts of the matter are that a completely efficient filter would permit the smoker to inhale nothing but hot air!

"Certainly there is no adequate evidence to prove conclusively that the reduction of nicotine

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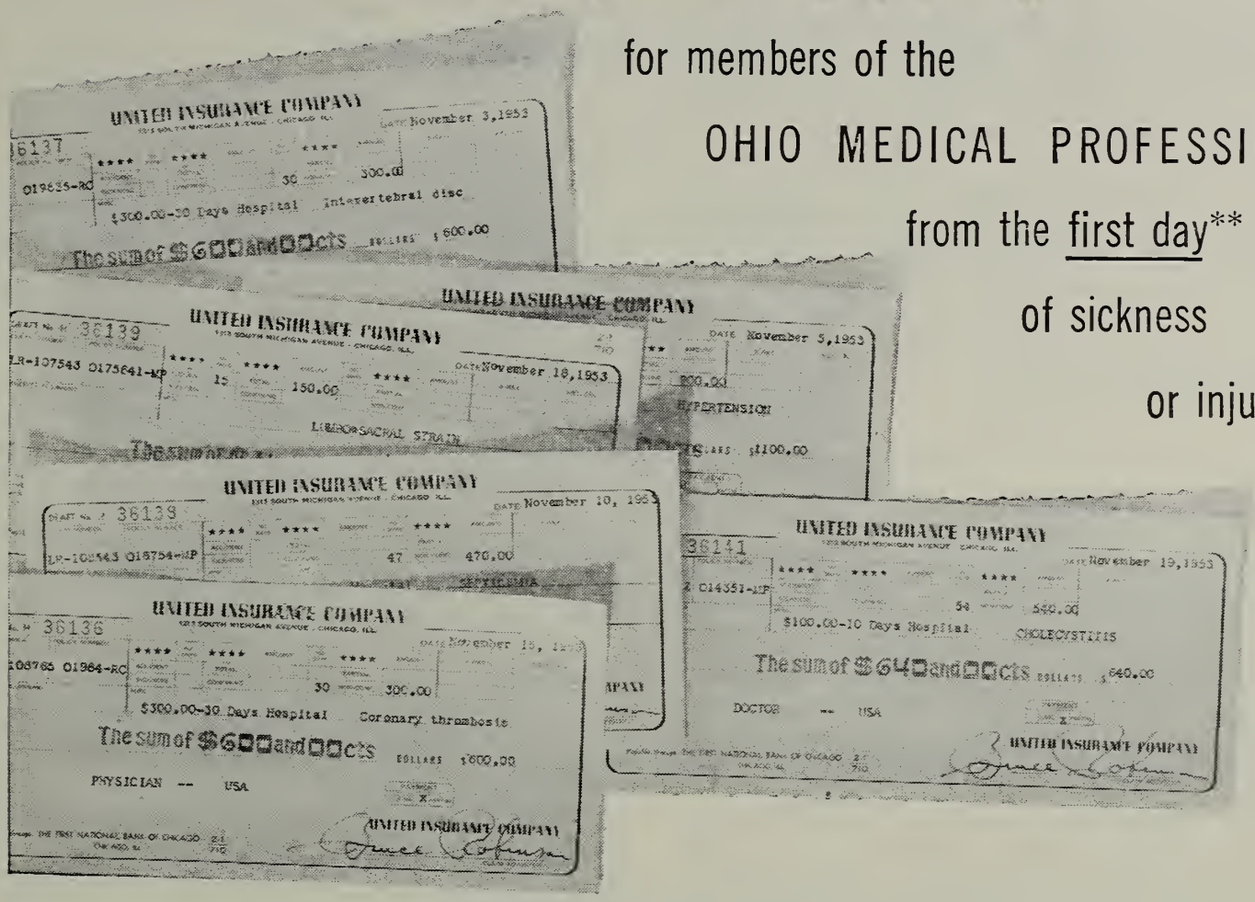
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OHIO MEDICAL PROFESSION

from the first day**

of sickness

or injury



now! Not for only 26 weeks—Not for only 52 weeks
but even for your entire lifetime
House Confinement is not required at any time
Accidental loss of hands, feet or eyesight pays
monthly benefits—not just lump sum

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I would like to know more about your lifetime protection.

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or clip to your letterhead

as advertised in The Journal of the American Medical Association

and tars by means of a filter that is 60 per cent inefficient has any physiological significance. The amount of nicotine and tars that reach the smoker's oral cavity is the one factor of fundamental importance. This cannot be determined merely by establishing the efficiency of a filter. The presentation of one fact and the exclusion of all other pertinent facts can result in a serious misrepresentation of the true status of health in relation to the smoking problem. Smokers who are misled are likely to obtain a false sense of security without real protection."

Under a revised advertising policy adopted by The Council in December, 1953, *The Ohio State Medical Journal* is not publishing tobacco advertising of any kind. This policy was adopted as a general principle, even though some tobacco companies have not mixed health and tobacco in their advertising claims.

ACTION PROMISED ON MATERNAL HEALTH PROBLEMS

Each member of the Ohio State Medical Association, specialist or general practitioner, should read the article in this issue of *The Journal* describing the five-year study of maternal mortality carried on in Franklin County. Especially, readers should reflect upon the conclusions set forth by the authors.

As the authors point out, such a study can be made in any other county, with certain modifications to meet local conditions. In fact, they recommend this. Also, they make a strong point when they state that the study demonstrates a need for further education in obstetrical problems, including early diagnosis of complications and adequate prenatal care.

The Council of the Ohio State Medical Association, having had knowledge of the Franklin County study, has decided to do something about the recommendations made by Drs. Meiling and Ruppersberg. In other words, The Council is not willing to regard the study as "just another study" for the archives.

On authorization of The Council, a Committee on Maternal Health has been created. It will be one of the working committees of the Association. One of its objectives will be to encourage the appointment of maternal health committees by all county medical societies. It will assist local committees in making studies similar to the Franklin County study and studies which have been made in a few other larger Ohio communities. It will cooperate with local committees in an educational program for the members of the medical profession, and the public.

This program promises, in time, to become one of the major educational, as well as public relations, projects of the Ohio State Medical Association.

POLL SHOWS SENTIMENT CLOSE ON S. S. LAW CHANGES

The Hon. J. Harry McGregor, the esteemed Congressman from the 17th Ohio District, has just completed polling his constituents on 10 questions of vital public interest—questions which are involved in proposals being considered by the U. S. Congress. Mr. McGregor's district includes the following counties: Ashland, Coshocton, Holmes, Knox, Licking and Richland.

One of the questions on the questionnaire was: "Do you favor the extension of social security coverage to 10.5 million additional persons, including doctors, dentists, ministers, farmers, and others who are self-employed, although this might possibly mean an increase in the rate paid by both the employer and the employee?"

Of the professional people who returned the questionnaire, 63 per cent voted "No" and 37 per cent voted "Yes," which indicates quite clearly how physicians, dentists, etc., feel. However, of all persons of all classes who voted, 49 per cent voted "No" and 51 per cent voted "Yes." There were certain groups who cast an overwhelming "Yes" vote, as might be expected, who brought about the narrow margin in the total vote. The largest number of "Yes" votes were cast by retired persons, ministers and public officer holders.

The breakdown by groups was as follows: Attorneys, 50 per cent, yes; 50 per cent, no; business, industry and salesmen, 49 per cent, yes; 51 per cent, no; farmers, 34 per cent, yes; 66 per cent, no; farm groups, 18 per cent, yes; 82 per cent, no; housewives, 43 per cent, yes; 57 per cent, no; labor, 53 per cent, yes, 47 per cent, no; ministers, 68 per cent, yes; 32 per cent, no; newspaper and radio, 29 per cent, yes; 71 per cent, no; occupation not given, 25 per cent, yes; 75 per cent, no; professional, 37 per cent, yes; 63 per cent, no; public office holders and Federal employees, 65 per cent, yes; 35 per cent, no; retired, 75 per cent, yes; 25 per cent, no; teachers, 59 per cent, yes; 41 per cent, no; students, 57 per cent, yes; 43 per cent, no.

Mr. McGregor secured a majority point of view, to be sure, but he undoubtedly will wish to analyze the vote, by groups, rather carefully before he makes a final decision on this question.

Fort Steuben Academy of Medicine

"Increasing Responsibilities of Anesthesiologists," was the topic discussed at the April 13 meeting of the Fort Steuben Academy of Medicine in Steubenville on April 13. Guest speakers were, Dr. Ralph M. Tovell, chairman, Department of Anesthesiology, Hartford Hospital, Hartford, Conn.; and Dr. Robert Lewis Patterson, attending anesthetist, Allegheny General Hospital, Pittsburgh; Dr. John P. Smarrella, Steubenville, was chairman of floor discussion.

The known clinical advantages of rapid absorption, wide distribution in body tissues and fluids, prompt response and excellent toleration, PROVED by the extensive experience of physicians in successfully treating many common infections due to susceptible gram-positive and gram-negative bacteria, rickettsiae, spirochetes, certain large viruses and protozoa, have established

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You and Your Public . . .

Four Goals Are Set for Medical Profession's Public Relations During Year; Newspapers Give Credit to Doctors for Service to Communities

ACCORDING to *The PR Doctor*, issued by the Public Relations Department of the American Medical Association, four goals are set for medical public relations for the year.

The primary goal is to focus the attention of every physician on the importance of good public relations, not only in Medical Society activities, but in his individual practice.

STRENGTH-UNITY

The second goal for the year is to develop a stronger, more unified profession. This would include programs such as the following:

1. Society indoctrination programs for new members.
2. Revitalization of all medical societies to increase member participation.
3. Presentation of a united front on medical issues, supporting the stand of the medical profession on campaigns of national scope.
4. Increase of society and individual community participation; sponsorship of good citizenship and get-out-the-vote campaigns.
5. Work with medical students, interns and residents; aid to Student A.M.A. chapters, making available material on socio-economic subjects and public relations, and sponsorship of public relations courses.
6. Reduction of professional jealousy and unwarranted criticism of one doctor by another. Such actions harm all doctors in the eyes of the public.

UTILIZATION OF PR OUTLETS

The third goal is to "utilize every public relations outlet to tell medicine's positive story." This would include such projects as suggested below:

1. Presentation of radio and television programs, using A.M.A. transcriptions or films, or development of local shows.
2. Sponsorship of health forums in cooperation with newspapers.
3. Continuation of efforts to develop good press cooperation and when possible, suggestion of ideas for local features on medical subjects.
4. Reactivation of the society's speakers bureau.
5. Preparation of leaflets describing local medical facilities for newcomers.
6. Medical exhibits at fairs and public gatherings.
7. Use of the public relations potential of the Woman's Auxiliary.

MENDING PR FENCES

Goal number four involves the mending of public relations fences to eliminate complaints about medicine. Some of the suggestions concerning this goal are as follows:

1. Mediation committees to help eliminate misunderstandings between doctors and patients.
2. Well-publicized night and emergency telephone call systems, and assurance that the people of the community are covered at all times in event of emergencies.
3. Medical audits and tissue committees in hospitals.
4. Promotion of voluntary health insurance.
5. Training programs for medical assistants, especially in the field of public relations.
6. Encouragement of greater use of the A.M.A. plaques to stimulate fee discussions in the doctor's office, and thus eliminate fee misunderstandings.

DOCTOR'S ROLE RECOGNIZED

Two newspapers in Ohio gave a hearty boost recently to public recognition of the doctor's role in improving medical service in their communities.

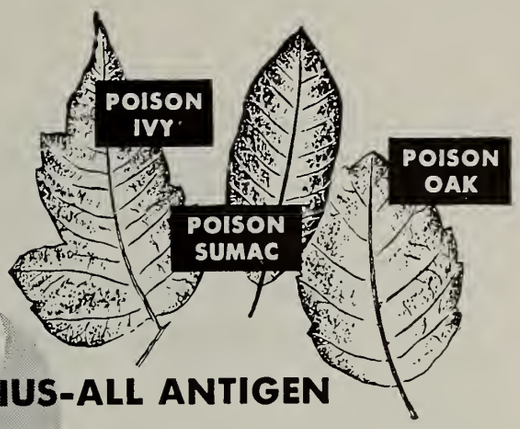
A series of three articles titled "Physicians and Philanthropy" was carried in the *Cincinnati Enquirer* as detailed proof of the extra burdens of time and effort carried by doctors in their constant attempt to improve public health.

In the first story, "He Only Charged Us—," James T. Golden, Jr., advised his readers to listen to the casual remarks of friends or strangers about their medical treatment. He bets they'll discover the remarks are most often concerned with the nominal sum the doctor charged. "Many of our M.D.s," the article said, "are doing an even finer job than their patients realize, are giving time, energy and often money in the service of the public and to professional improvement which ultimately benefits the public, too."

The second article in Golden's series related the free volunteer medical services available through the Academy of Medicine, including night and emergency telephone answering system and volunteer work in clinics. His third, "Some Very Special Groups," emphasized the continued advanced training seminars in which physicians enroll, hospital staff volunteer service, and the fine work done by doctors' wives in community affairs.

"You Can Get a Doctor," published in the *Akron Beacon Journal*, is a fine example of press cooperation in presenting the doctor's answer to complaints that medical care sometimes is not available, especially in emergencies. The story made prominent mention of the Doctors' Exchange phone number for night and emergency telephone service and urged families to choose

Summertime protection from



RHUS-ALL ANTIGEN

Rhus-All Antigen is a unique sterile almond-oil solution of the active principles extracted from the leaves of Poison Ivy, Poison Oak and Poison Sumac.

Rhus-All Antigen prevents all three common types of Rhus Dermatitis. Only one or two injections are usually sufficient to offer protection.

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Order Rhus-All Antigen today from your surgical supply dealer or

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Dept. D5, Detroit 14, Michigan

Please send me the following:

———Vials (5 cc.) of Rhus-All Antigen No. 150-5. Physicians' price $2.00. SPECIAL OFFER: 1 extra with order of 3 vials.

———Regular set (four 1 cc. vials) Rhus-All Antigen No. 150. Physicians' price $3.25. SPECIAL OFFER: 1 extra with order of 3 sets.

———Complimentary copy of "Handbook of Allergy for the General Practitioner."

DR._____

STREET_____

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Phone: 5766

their family doctor and to become acquainted with him before an emergency arises. "Obtaining the services of a family physician is not difficult. . . . A call to the Summit County Medical Society will bring a list of doctors willing to accept new patients," the story advised.

Encouraging your local paper to print such articles about physicians and medical societies is often the most direct way to point up the doctor's role in the life and health of your community.

* * *

According to *The PR Doctor*, Dover, Ohio, residents are confronted with a pointed question each Tuesday when they open their hometown newspaper, *The Dover Daily Reporter*. A series of advertisements asking "Do You Have a Family Doctor?" emphasizes the importance of selecting a physician to whom a family can turn in an emergency. The ad urges families without a personal physician to request a list of doctors from the Tuscarawas County Medical Society.

"The family doctor is ordinarily a general practitioner, a doctor of medicine, who has received his M.D. degree from a recognized school of medicine and who has had at least one year of internship in an approved hospital," the ad states. "Once having selected a doctor, go to his office and get acquainted with him so that he knows you when you need to phone him about some illness or emergency which might arise in your family. Your first thought when an emergency or illness arises should be your Family Doctor."

The ad is sponsored by the staff of the Dover-New Philadelphia Union Hospital and has been running weekly for several months. Although the majority of county medical societies sponsor night and emergency call systems, ads such as this one can lighten the number of calls from families who have not selected a doctor before illness occurs or who are unaware that their local society can offer them information on physicians in their community.

* * *

Many a medical society seeks an inexpensive throw-away piece of literature which can be distributed at county fairs and other public meetings. The Jefferson County Medical Society in Louisville, Ky., has produced a colorful leaflet for this purpose entitled "Yours for Service," which very briefly described such medical society activities as the emergency call service, mediation committee, speakers' bureau and so forth. This illustrative leaflet was produced at a cost of one-fourth of a cent per copy.

Western Reserve University is recipient of a $31,306.30 research grant from the National Foundation for Infantile Paralysis. The project is under direction of Dr. Frederick C. Robbins, professor of pediatrics.

Do You Know? . . .

Dr. Irvine H. Page, Cleveland, was named president-elect of the American Heart Association at the recent Chicago Meeting. Dr. Irving B. Hexter, also of Cleveland, was named a member of the directors-at-large.

* * *

Dr. Roger M. Gove, for several years superintendent of the Columbus State School, has been named assistant commissioner to the Department of Public Welfare's Division of Mental Hygiene, which is under direction of Dr. Lowell O. Dillon, commissioner.

* * *

Hart F. Page, assistant director of public relations, Ohio State Medical Association, has been appointed program secretary for the 35th National Convention of Sigma Delta Chi, professional journalistic fraternity, November 10-13 in Columbus, according to the organization's national president, Robert U. Brown, editor of *Editor and Publisher* magazine.

* * *

Dr. Ewing H. Crawfis, recently deputy director of California's Department of Mental Health, has been named superintendent of the Arkansas State Hospital in Little Rock. Dr. Crawfis formerly was clinical director of the Cleveland State Hospital and before that was at the Lima State Hospital.

* * *

Dr. Robert N. Watman, of Ohio State University, has been named one of 25 "scholars in medical science" selected from faculty members of medical schools throughout the country and Canada to receive a grant from the John and Mary R. Markle Foundation, New York City. The grant means that Ohio State will receive $30,000 over a period of five years.

* * *

Dr. Arnold Lazarow, associate professor of anatomy at Western Reserve University School of Medicine, will leave this summer to accept a post as head of the Department of Anatomy, University of Minnesota.

* * *

An example of how physicians in medium sized towns are furnishing emergency service to the community is found in Fairborn. Announcement is made through the newspapers of the name of the doctor who will be on emergency call for the week.

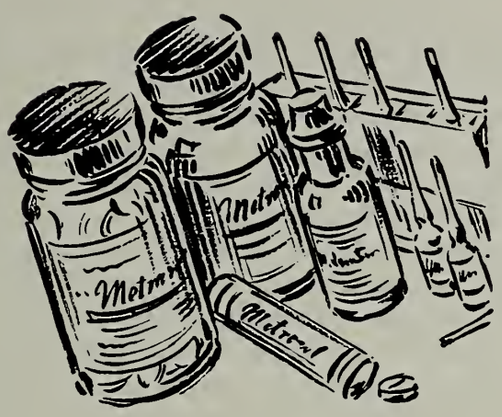
* * *

A portrait of Dr. Charles E. Holzer, Sr., by Professor J. W. Grimes, of the Fine Arts Department, Ohio State University, was presented to Holzer Hospital, Gallipolis, by Dr. and Mrs. Charles E. Holzer, Jr.

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In respiratory and other emergencies resulting from medullary depression during anesthesia. Ampules 1 and 3 cc., tablets, solution, powder.

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A three months combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology; bacteriology and embryology; physiology; neuro-anatomy; anesthesia; physical medicine; allergy; examination of patients pre-operatively and follow-up post-operative in the wards and clinics; attendance at departmental and general conferences.

PROCTOLOGY AND GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; witnessing operations; ward rounds; demonstration of cases; pathology; radiology; anatomy; operative proctology on the cadaver; attendance at departmental and general conferences.

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A three year course, beginning in October, fulfilling all the requirements of the American Board of Dermatology and Syphilology. Also five-day seminars for specialists, for general practitioners, and in dermatopathology.

RADIOLOGY

A comprehensive review of the physics and higher mathematics involved, film interpretation, all standard general roentgen diagnostic procedures, methods of application and doses of radiation therapy, both X-ray and radium, standard and special fluoroscopic procedures. A review of dermatological lesions and tumors susceptible to roentgen therapy is given, together with methods and dosage calculation of treatments. Special attention is given to the newer diagnostic methods associated with the employment of contrast media such as bronchography with Lipiodol, uterosalpingography, visualization of cardiac chambers, pre-renal insufflation and myelography. Discussions covering roentgen departmental management are also included; attendance at departmental and general conferences.

FOR INFORMATION ABOUT THESE AND OTHER COURSES ADDRESS—
THE DEAN, 345 West 50th Street, New York 19, N. Y.

In Memoriam . . .

William L. Brodberger, M. D., Cincinnati; Eclectic Medical College of Cincinnati 1901; aged 73; died March 8; member of the Ohio State Medical Association through 1950. Dr. Brodberger practiced medicine in Cincinnati from the completion of his medical education until his retirement about six years ago, with some time off for study in Europe.

William R. Burkhart, M. D., Cleveland; Western Reserve Medical College, 1895; age 87; died March 16 in New York. Dr. Burkhart was a practicing physician for many years in Cleveland. A son and a daughter survive.

Leo R. Courtright, M. D., Dayton; Ohio State University College of Medicine, 1909; aged 67; died March 20; member of the Ohio State Medical Association. Dr. Courtright retired early in 1952 after practicing approximately 43 years in Dayton. During World War I, he served with the Army Medical Corps. His practice included many years of service on the health staff of the city as a district physician. Affiliations included memberships in several Masonic bodies and the Methodist Church. Surviving are his widow and a daughter.

Otto Philip Geier, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1897; aged 79; died February 28; member of the Ohio State Medical Association and member of the American Medical Association. Dr. Geier practiced in Cincinnati from the turn of the century until his retirement in 1946. He came out of retirement in 1953 to take part in the program for fluoridation of the city water supply, during which period he was on the Committee on Industrial Medicine and Health of the Cincinnati Academy. Some years ago Dr. Geier was a member of The Council of the State Association representing the First District. In 1914 he pioneered in the field of industrial medicine by associating himself with the Cincinnati Milling Machine Company where he instituted an industrial medical service. Dr. Geier was one of the organizers of the American Association of Industrial Physicians and Surgeons in 1915. Hs was active also in a number of civic enterprises, among them the campaign on the local and state level to bring about sanitary conditions in the milk supply. In 1925 he served on the League of Nations Medical Committee which investigated living and working conditions in Europe. He was a past-president of the local Anti-Tuberculosis League and active in establishing Blue Cross in Cincinnati. Dr. Geier was a charter member of the Community Chest, a member of the Public Health Federation, one of the founders of the University Club, past-president of both the Literary Club and the McDowell Club, a member of the Cincinnati Country Club and of Beta Theta Pi. Survivors include his widow, a son, two brothers and a sister.

John Von Der Au Horst, M. D., Mansfield; Ohio State University College of Medicine, 1925; aged 53; died February 26; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Horst had been chief medical officer at the Ohio State Reformatory since 1941. He served as a Navy physician during World War II and was a member of the Naval Reserve. Early in his career, he served as a medical missionary in Siam. Affiliations included memberships in the Presbyterian Church and the Masonic Lodge. Surviving are his widow, two sons, two daughters, two brothers and three sisters.

Milfert Weaver Myers, M. D., Warren; University of Maryland School of Medicine, 1915; aged 63; died March 11 while vacationing in Florida; member of the Ohio State Medical Association; member of the American Medical Association. Dr. Myers practiced for many years in Niles before moving to Warren in 1937. He was a member of the Masonic Lodge. Survivors include his widow, a son and a daughter.

Michael F. Oman, M. D., Cleveland; University of Minnesota Medical School, 1923; aged 63; died March 19; member of the Ohio State Medical Association; member of the American Medical Association; delegate of the Academy of Medicine of Cleveland, 1942-1943. Dr. Oman had practiced for more than 30 years in Cleveland where he was chief of the Department of Gynecology, Euclid-Glenville Hospital. He was past-president of the board of trustees of the former Glenville Hospital and a member of the board of the combined hospital. He was a member of the Catholic Church, Phi Xi. Surviving are his widow, four brothers and a sister.

Clarence Crump Ross, M. D., Columbus; Cincinnati College of Medicine and Surgery, 1894; aged 85; died March 18; former member of the Ohio State Medical Association. Dr. Ross served all of his professional career in Columbus. He was a trustee of the Methodist Church, a member of the Masonic Lodge and a member of the Ohio State Archeological Society. Surviving are a daughter and three sons, one of whom is Dr. Paul S. Ross, also of Columbus.

Lear H. Van Buskirk, M. D., Columbus; Ohio State University College of Medicine, 1922; aged 67; died March 31; member of the Ohio State Medical Association and member of the American

DETAILED REPORTS OF THE 1954 ANNUAL MEETING WILL APPEAR IN THE JUNE ISSUE

Because of the time element, it was not possible to include in this issue reports of the 1954 Annual Meeting which was held in Columbus, April 12-15. Details, including biographical sketches of new officers, proceedings of the House of Delegates, reports of attendance and other highlights, will appear in the June issue of *The Journal.*

Medical Association. Dr. Van Buskirk served all of his professional career in Columbus where he was on the faculty of the O. S. U. College of Medicine and on the staff of St. Francis Hospital. A varsity football player in 1907 and 1908 at Ohio State, he received his degree in chemical engineering and later studied medicine while in charge of the State Board of Health laboratories. He was a member of the Congregational Church, the Athletic Club, Beta Theta Pi and Phi Rho Sigma. Survivors include his widow and a son, Dr. Gordon Van Buskirk, of Chambersburg, Pa.

New Members of O.S.M.A.

The following are the names of the new members of the Ohio State Medical Association since March 5, 1954. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ASHLAND COUNTY
William H. Rower, Ashland

ASHTABULA COUNTY
Kathryn Potts, Ashtabula
Lew W. Potts, Ashtabula

BELMONT COUNTY
C. R. Apel, St. Clairsville

FRANKLIN COUNTY
William E. Copeland, Columbus
Walter A. Holbrook, Columbus
Alfred F. Slivinski, Columbus

GUERNSEY COUNTY
Peter Kazlauskas, Cambridge

HAMILTON COUNTY
Hugh J. Bonner, Cincinnati
Edgar O. Demar, Madeira
William E. Heil, Cincinnati
Harlen B. Merkle, Cincinnati
Harold Moskovitz, Cincinnati
Louis Schwab, Cincinnati
Paul J. Singer, Cincinnati
Ivan Tuskan, Cincinnati
James R. Ward, Cincinnati

LUCAS COUNTY
Woodruff C. Adams, Toledo
George F. Alter, Toledo
Frank E. Foss, Toledo
Robert H. Garrett, Toledo
Frank M. Good, Toledo
Hugh R. Jones, Toledo
E. H. Koster, Toledo
Lucille Richardson, Toledo
Robert N. Smith, Toledo
Wil'ys L. Woodward, Toledo

MEDINA COUNTY
Frank B. Metting, Wadsworth
Paul P. Parker, Wadsworth

MONTGOMERY COUNTY
Rudolph V. Basso, Dayton
Roy C. Rounds, Dayton

PUTNAM COUNTY
Will W. Moody, Vaughnsville

ROSS COUNTY
Douglas A. Sargent, Chillicothe

SANDUSKY COUNTY
Karl K. Grubaugh, Woodville

SUMMIT COUNTY
Wilfred B. Bozeman Jr., Akron
Bartholomew Clemente, Akron
Wiley B. Trivett Jr., Akron
Louis M. Walker, Akron

WARREN COUNTY
Howard G. Berninger, Lebanon

Miss Cranz To Succeed Mrs. August In Nurses' Association Position

Appointment of Miss Celia Cranz, R.N., former director of the School of Nursing of Akron City Hospital, to the position of General Secretary of the Ohio State Nurses' Association has been announced.

Miss Cranz will succeed Mrs. Elizabeth P. August, R.N., of Columbus, who has held this position since 1923, and who has resigned this post effective August 31.

Mrs. August, who will retire to private life following nearly 31 years' with the association has been a leader in state and national nursing activities since 1912.

The Association also has named Mrs. Julia Fishbaugh, R.N., Marysville, to the newly created post of Associate General Secretary, to assume her duties September 1. She is a graduate of Mt. Carmel Hospital School of Nursing, Columbus, and has both her Bachelor of Science and Master's degrees in education from George Peabody College for Teachers.

A graduate of the City Hospital of Akron School of Nursing, Miss Cranz received her Bachelor of Science degree in education from Teachers College, Columbia University. She held the position of Director of the School of Nursing of Akron City Hospital from 1926 to December, 1953.

Miss Cranz was appointed a member of the first State Nurses' Board created under Ohio's former governor John W. Bricker, and served as chairman during her five-year term.

She served as President of the Ohio State Nurses' Association from 1938-1940, and was then elected to the Board of Trustees for a four-year term. Since then she has been Chairman of the State Section on Nursing Education and Chairman of a number of special committees. At present she is a member of the special committee on Studies of Nursing Functions, and is also the Association's representative on the Civil Defense program.

The nation's population of veterans with service since the outbreak of Korean fighting now stands at nearly 2,500,000, Veterans Administration announced.

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D., MIDDLETOWN)

HAMILTON

Following are features of recent meetings of the Academy of Medicine of Cincinnati:

March 2—"Drugs in the Treatment of Heart Disease," Dr. Charles K. Friedberg, assistant clinical professor of medicine, Columbia University College of Physicians and Surgeons.

March 16—"New Concepts about Thrombocytopenic Purpura, Sensitivity to Platelets, and Platelet Types," (Roger Morris Lecture), Dr. Carl Vernon Moore, professor of medicine, Washington University School of Medicine, St. Louis.

April 6—"Drug Therapy of Malignant Diseases," Dr. Maxwell M. Winthrobe, professor and head of Department of Internal Medicine, University of Utah College of Medicine.

HIGHLAND

Members of the Highland County Medical Society at the March 3 meeting voted to go on record as being opposed to a Social Security program for doctors.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

DARKE

Dr. Peter Saunders, Dayton, spoke on the subject "Anesthesia for T. and A." at the March 16 dinner meeting of the Darke County Medical Society in Greenville.

GREENE

Dr. Richard Graves, at the March 11 meeting of the Greene County Medical Society, spoke on the subject, "Pediatric Urology," which included a discussion of the anomalies of the urinary tract and infections of the urinary tract in children.

The proposed Home Nursing Pilot Program to be tried in five counties, including Path Township of Greene County, was approved by vote of members.

At the April 8 meeting, Dr. John Burnett, Springfield, spoke on the subject, "Carcinoma of the Cervix."

MONTGOMERY

A panel discussion on the subject "Surgical Diseases of Infancy and Childhood" constituted the scientific program at the April 2 meeting of the Montgomery County Medical Society in Dayton. The subject was presented by three members of the teaching staff of the University of Michigan—Drs. Robert W. Buxton, W. C. Baum and Herbert E. Sloan, Jr.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

The regular dinner meeting of the Lima and Allen County Academy of Medicine was held at the Shawnee Country Club on March 16. The subject "Acute Head Injuries" was discussed by Dr. Kenneth Abbott, Department of Neurology, Ohio State University College of Medicine.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

Guest speaker for the Inter-Hospital Postgraduate Lecture Series was Dr. Richard W. Te Linde, professor and head of the Department of Gynecology, Johns Hopkins Hospital. The series, presented by the Medical Advancement Trusts of the Maumee Valley Hospital and the Toledo Chapter, American College of Surgeons, was given on March 25 and 26. Subjects discussed were, "Unjustified Pelvic Surgery"; "Carcinoma of the Cervix Including Carcinoma in Situ"; "Urinary Aspects of Gynecology"; "Endometriosis"; "Treatment of Malpositions of the Uterus and Allied Conditions"; "Ovarian Tumors."

Other March features included the following subjects discussed at meetings of the Academy of Medicine of Toledo:

"The Problem of Accreditation of Hospitals," Dr. John Hinman, Chicago, March 5, General Section meeting.

"The Diagnosis and Treatment of the Common Hemorrhagic Diseases," Dr. Armand J. Quick, professor of biochemistery, Marquette University, March 12, Section on Pathology.

"Theoretical and Clinical Factors Influencing the Choice of an Antibiotic," Dr. Thomas F. Paine, Jr., associate professor of bacteriology and internal medicine, University of Michigan, Medical Section.

Five weekly color television programs on cancer, sponsored by the American Cancer Society, also were seen in the Academy building on Wednesday evenings.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

The Mahoning County Medical Society and the Mahoning Academy of General Practice held a combined meeting on March 16 at the Youngstown College Library Building. Dr. Donald M. Glover, clinical professor of surgery, Western Reserve, spoke on the subject, "Emergency Surgery in Infants and Children."

Another combined meeting was held on April



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20 with Dr. Murray M. Copeland, professor of oncology, Georgetown University Medical Center, Washington, D. C., speaking on the subject, "Lumps in the Breast—Their Significance."

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

TUSCARAWAS

The regular meeting of the Tuscarawas County Medical Society was held at the Union Hospital Auditorium on April 8. Dr. Robert E. Brubaker, Akron, spoke on the subject, "The Practical Aspects of Fluid and Electrolyte Balance."

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

A panel discussion on the subject "Home Care of Poliomyelitis" was held at the March 15 meeting of the Columbus Academy of Medicine in the Columbus Gallery of Fine Arts. The panel consisted of Dr. Warren Wheeler, chairman; Drs. Earl Baxter, Ollie Goodloe, Charles McClave, Paul Miller, Fred Wentworth and Ralph Worden.

ROSS

The Ross County Academy of Medicine met on April 1 with President N. H. Holmes presiding. There were 24 members and associate members present at the Lynne House.

A letter from the Public Relations Department of the A. M. A. was read and the Secretary was instructed to answer, stating that people in the locale were being cared for and no further publicity was needed regarding emergency medical services. The question of advertising to advise newcomers to contact a family doctor prior to midnight illness was strongly disapproved. It was suggested that the Public Relations Committee request a newspaper article portraying the role of the County Society in the community.

The Society voted to endorse the Blue Cross-Blue Shield plans for the coming subscription campaign. A request from the Chillicothe Ministerial Association that the Society be represented on a Family Council was referred to the Public Relations Committee. Dr. Swank reported that the Board of Censors was in action, considering the applications before it. The Secretary read applications for membership received from Dr. David McKell and Dr. Paul F. MacCarter.

Dr. Ralph Holmes, delegate to the Ohio State Medical Association, asked the Society's pleasure and was directed to support the proposed amendment to the O. S. M. A. By-Laws in regard to excusing certain members from payment of State dues.

Dr. G. H. Wood presented Dr. Lester Bossert, director of the gyenecological service, University of Cincinnati, who discussed common gynecological problems.—Lewis W. Coppel, M. D., Secretary-Treasurer.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

Twenty members of the Lorain County Medical Society were guests of the Lorain County Bar Association at a March dinner meeting where Howard Lutz, former prosecutor of Ashland County, gave a talk on medical evidence.

RICHLAND

Sixty-three members of the Richland County Medical Society met at Mansfield General Hospital Thursday, March 18. Dinner was served at the hospital, and a business meeting and program followed.

Dr. G. H. Wenger of Massillon, Ohio, addressed the group on "Office Proctology."

A report on the proposed field trial in Richland County for the new polio vaccine was presented by Dr. John D. Porterfield, Ohio Director of Public Health. Members of the Richland County Medical Society reaffirmed their support of the program and volunteered to give inoculations to children in the first, second, and third grades during the test — P. O. Staker, M.D., Secretary.

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Activities of Woman's Auxiliary . . .

BUTLER

At the last meeting held in the Hamilton Y.W.C.A., a talk was given by an insurance company representative on "Estate Planning." It was voted to pay part expenses of sending a local person to the Civilian Defense School at Alney, Md. for a week's training.

CLINTON

Members of the auxiliary, who also comprise the membership of Twig 1 of the Clinton Memorial Hospital Women's Guild, sponsored the annual Hospital Ball at the General Denver Hotel, Wilmington, Saturday, Feb. 13. Proceeds will go toward the cystoscopic room at the hospital. Co-chairmen for the Ball were Mrs. Frank G. Plymire and Mrs. Nathan S. Hale.

Newly elected officers for the coming year are: Mrs. W. L. Wead, President-elect; Mrs. H. Richard Bath, Vice-President; Mrs. Richard Cronebaugh, Secretary; Mrs. R. H. Vance, Treasurer.

COSHOCTON

Mrs. I. B. Kistler was hostess for the March meeting. Mrs. G. A. Foster was appointed Civilian Defense Chairman. A talk was given by Aston Stewart, local engineer, and assistant director of the Coshocton Civilian Defense program.

DELAWARE

The Heart Drive, sponsored by the local auxiliary, was responsible for collecting twice the amount of last year.

At the Nurse Recruitment Tea, a $100 nurse scholarship was awarded to a local girl attending Ohio State University. Mrs. George Parker, the vice-president, introduced the guest speaker, Miss Freda Stewart, assistant director of nursing at the Ohio State School of Nursing.

Mrs. F. M. Stratton presided at the tea table. Members elected the following officers for the coming year: Mrs. J. G. Parker, president; Mrs. G. J. Parker, president-elect; Mrs. E. V. Arnold, vice-president; Mrs. D. L. Gantt, secretary; Mrs. F. M. Stratton, treasurer.

ERIE

Under the chairmanship of Mrs. C. E. Lavender and including Mesdames C. E. Swanbeck, F. O. Fry, William Burger, Paul N. Squire and D. M. Spencer, the Auxiliary has put on an extensive program for nurse recruitment. A series of three radio programs featuring local nurses and hospital personnel was given during March and members of the committee have talked before various service clubs on behalf of the program.

FAIRFIELD

The Auxiliary entertained at tea members of the faculty of the Lancaster-Fairfield County Hospital, Registered Nurses, Student Nurses, and Junior and Senior High School girls interested in becoming nurses. The tea was held in the Nurses' Home. Mrs. W. M. Jasper was chairman. One hundred and thirty-nine students attended. The girls were introduced to the Hospital Faculty and escorted on a tour of the Nurses' Home. The guests were also shown a film "When You Choose Nursing." As a prelude to the tea, Miss Lillian Pierce, director of Education at the Schools in Fairfield, had given talks at seventeen High Schools in Fairfield and adjoining counties.

FRANKLIN

Mrs. N. M. Reiff, State President, was a guest at the March meeting when Mrs. Frank Lausche was the guest speaker. Mrs. E. R. Schumacher served as chairman for the meeting. Mrs. Rivington Fisher introduced Mrs. Lausche, who talked on "Know Your Mansion."

GREEN

Mrs. W. B. Mansur, director of the Second District, spoke at the March meeting held at the home of Mrs. Mary Little Dice. Mrs. E. C. Fishbein of Dayton was a guest at the meeting. Mrs. S. C. Ellis, president-elect, conducted in the absence of the president, Mrs. Richard F. Kelly. Hostesses assisting Mrs. Dice were Mrs. Lawrence Shields, Mrs. P. B. Wingfield, and Mrs. L. W. Sontag.

HAMILTON

Three Auxiliary members, Mrs. Daniel V. Jones, Mrs. Charles Sherrick, and Mrs. John D. Marion, participated in a choral program presented in March for members of the Cincinnati Symphony Club.

At the January meeting, Polly Cramer, interior decorating writer for the Post, spoke on "Inside the House — Upstairs and Down." Program chairman for the day was Mrs. Daniel E. Earley. Mrs. Joseph E. Ghory is vice-chairman in charge

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**English, A. R., et al.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.*

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of arrangements. Mrs. Robert H. Kotte, the president, conducted a short business meeting. Hospitality chairman was Mrs. Stanley Dorst assisted by Mesdames Edward J. McGrath, Richard W. Vilter, Virgil Plessinger, Charles D. Aring, and Mrs. Henry Ryder.

Mr. Harold R. Muntz, Chief Probation Officer of the Juvenile Detention Home, spoke at the February meeting on "Outlook on Juveniles." Dr. Dale P. Osborn, President of the Cincinnati Academy of Medicine, and advisor to the Auxiliary, was an honored guest. Mrs. Gerald H. Castle, program chairman of the day, introduced the speaker. Mrs. Eugene Fromam served as vice-chairman, and Mrs. Joseph Crotty hospitality chairman. At the March meeting Mrs. J. Stewart Mathews and Mrs. Warren L. Strohmenger were co-chairman of hospitality. "Vacuum Patterns—Thoughts On Your Design For Living" was the topic of the talk given by Kenneth Kurtz, divisional sales manager of the Automotive Refinish Trades for the Minnesota Mining and Manufacturing Co. He was introduced by Mrs. Donald J. Jacobs, program chairman.

KNOX

The March meeting of the Auxiliary was held at the home of Mrs. Robert L. Eastman, when new officers were elected. They are: Mrs. Joseph Allman, president; Mrs. Julius Shomansky, president-elect; Mrs. Delbert Schmidt, vice-president; Mrs. James McLarnan, secretary-treasurer; Mrs. C. E. Cassaday was chairman of the Nominating Committee. Mrs. Thomas Bogardus, Mrs. John Drake, and Mrs. O. W. Rapp reported on "Public Health in the City and County," the nurses' scholarship, and "Today's Health" respectively. Mr. Bill Roat of the High School spoke on "Pupil Personnel Services in Our Schools."

LOGAN

Mrs. J. M. McBride of Lima, director of the Third District of the Auxiliary, was a guest at the last meeting held in the home of Mrs. Charles Thompson. The election of officers resulted as follows: Mrs. Thompson, president; Mrs. Hobart L. Mikesell, president-elect; Mrs. Warren F. Mills, vice-president; Mrs. R. A. Firman, recording secretary; Mrs. F. Blair Webster, corresponding secretary, and Mrs. Frederick W. Kaylor, treasurer.

LORAIN

Warren A. Guthrie, TV reporter, was the guest speaker at the March meeting held in Spring Valley Country Club. Mrs. G. J. Krupp, program chairman, introduced the speaker, and Mrs. Theodore Finegan, president, conducted the meeting. The new officers for the 1954-55 term elected were: Mrs. V. A. LaFleur, president; Mrs. Theodore Berg, president-elect; Mrs. Henry Drygas, vice-president; Mrs. H. E. McDonald, recording

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secretary; Mrs. Dennis Radefeld, corresponding secretary, and Mrs. Roy E. Hayes, treasurer.

LUCAS

In cooperation with the Toledo Women's Traffic Council, the Auxiliary helped place in Toledo and Lucas County taverns, some 1000 posters which read "Drunk Drivers Go To Jail."

Mrs. John Dickie, a member of the Auxiliary, was honored recently through an article in the *Toledo Blade* written concerning her many and outstanding activities at St. Vincent's Hospital there.

The Auxiliary was one of the teams participating in the recent Red Cross Drive.

Mrs. John Buck and Mrs. Hazen Haumen were hostesses in February for the brunch given in the Academy Building for the Women's Guild of the Lucas Chapter, National Infantile Paralysis Foundation.

Mrs. C. L. Stevers, Mrs. Ward Meyers, and Mrs. Samuel D. Zuker are Auxiliary members who participated in the recent distribution of scrolls to be signed for the "Crusade for Freedom."

The mental hygiene study group met in the Academy Building. Hostesses were Mrs. Walter Greenom, Mrs. Henry Burstein, Mrs. Mervin Green, and Mrs. Joseph Westhoven. The child study development group met in the home of Mrs. Wm. Telfer with Mrs. Jack Burnheimer and Mrs. Raymond Beitzel as hostesses. Mrs. Henry Hartman is chairman of the mental hygiene group and Mrs. Wm. Phillips of the child study.

In March the afternoon Live Issues of Today Study Group met at the home of Mrs. David Kotchka. Mrs. Bernard Steinberg was chairman for the day. Mrs. Harry Scott, Mrs. Morris Silman, and Mrs. C. J. A. Paule conducted the discussion.

The evening session met at the home of Mrs. Theron Hopple. Mrs. Gordon Todd and Mrs. Max Schnitker led the discussion. Mrs. Robert Ulrich assisted the hostess.

At the February meeting Judge Henry J. Robison, Columbus, state director of public welfare, spoke on "The Mental Health Situation in Ohio." Representatives of fifty organizations were invited to attend. Mrs. Hazen Hauman reported on the Mothers' March on Polio and Mrs. Henry Hartman discussed mental hygiene facilities in Toledo. Mrs. Elmer Haynes and Mrs. Harvey Gunderson were co-chairmen for the tea which was served following the program.

Mrs. Franklin Earnest III was chairman of the auxiliary-academy supper dance committee in the ballroom of the Commodore Perry Hotel. Serving with her were Mrs. Henry Cook, co-chairman, Mrs. John Dickie, tickets and reservations; Mrs. Ralph Zucker, costumes; Mrs. William Newborn, announcements; Mrs. Samuel Zukor, food and



decorations, and Mrs. William H. Eyster, Jr., telephone. Jimmy Tohr's orchestra played for dancing. A buffet supper was served at 11:30 p. m.

Guests of honor were Dr. Edward J. McCormick, president of the American Medical Association and Mrs. McCormick; Dr. Robert A. Martin, president of the Toledo Dental Society, and Mrs. Martin; Dr. Leo Cunningham and Mrs. Cunningham, president of the Toledo Dental Auxiliary; Dr. Howard M. Bowman, chairman of the biology section at the University of Toledo, and Mrs. Bowman; Robert Elwell, executive secretary of the academy and Mrs. Elwell; and Mary Gallagher and Barbara Rygolwski, of the executive staff. Hostesses for the evening were Mrs. Emidio Gaspari, Mrs. Edward L. Doermann, Mrs. A. Paul Hancuff and Mrs. Myron G. Means.

MIAMI

The Auxiliary met for a luncheon meeting at the new Dettmer Hospital in February. Final arrangements were made for the dance in April. After some discussion the members decided to award two five hundred dollar scholarships this year since we do have sufficient funds to do so. The winners of the awards were then decided upon. Literature on the Cancer Fund Drive was distributed. The president gave a report on the meeting of the State Nominating committee which she attended.

MONTGOMERY

"America's Foremost Authority on Travel," Carol Lane, discussed "An Open Mind for the Open Road," in a talk before the auxiliary at the March meeting. There was a luncheon preceding Miss Lane's talk in the Biltmore Hotel Grand Ball Room. Hostesses for this outstanding event were the following: Mesdames Robert Humphrey, Sidney Copland, J. A. Mendelson, Richard Sauer, and N. J. Birckbeck. High-lighting Miss Lane's talk was a visual demonstration of how to plan a two-week vacation wardrobe. Miss Lane, who is Women's Travel Director, Shell Oil Company, showed the four basic costumes necessary for any two-week vacation and explained how they can be mixed and matched to provide a complete travel wardrobe.

In addition she told how to take "Tourettes" (week-ends), and to make travel an adventure in learning for children, and how to plan a travel budget. Miss Lane presented each guest with her booklet, Carol Lane's vacation "Dress-O-Graph," which tells how to enjoy a whole trunkful of vacation costumes from one suitcase of well-planned clothes.

ROSS

Ross County Civil Defense Chairman, Dr. Henry Luidens, was the speaker at the April dinner meeting held in Allyn's dining room. Mrs. Luvis Coppel and Mrs. G. Howard Wood were

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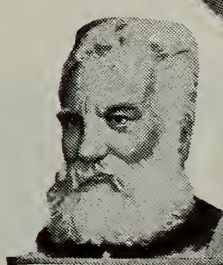


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appointed delegates to the State meeting in Columbus. Plans for the Nurse Recruitment Tea and the auction were discussed. Mrs. Nicolas Holmes, the retiring president, conducted the meeting at which time the new officers were introduced. They are: Mrs. Wood, president; Mrs. Robert Giesler, vice-president; Mrs. John Berneo, secretary; and Mrs. Buell Ashmore, treasurer.

STARK

A film, "The Angry Boy" was shown by Dr. M. Kirk Miller, director of Stark County Guidance Center, at the March meeting. Mrs. Samuel J. Feingold was program chairman, and Mrs. Oscar Clovis, hostess chairman.

SUMMIT

The March meeting was held in the Nurses' Home of City Hospital. Mrs. Norman P. Auburn reviewed the book "The Second Six" by Simone de Beauvoir. Members of the Dental Auxiliary were invited as guets, and tea was served following the program.

A glowing report on the Seventh Annual Health Days Exposition has been submitted by Mrs. Hubert Senne, chairman of the Health Days Committee. This year forty-eight public and private health and welfare agencies presented exhibits. New exhibitors were the Arthritis and Rheumatism Association, Rehabilitation Center, University of Akron, and Retarded Children. The electro-encephalograph machine demonstrated by Children's Hospital was also new this year. The Diabetic Detection booth was set up by the Medical Society and the Health Department as a pilot study to determine whether mass screening is feasible. Funds for the diabetic survey were contributed by the Medical Society, the Akron Junior League and this Auxiliary.

Total attendance was 16,192. 504 encephalograms were done. 2,400 chest x-rays were taken. Red Cross did 3,050 blood pressures and hemoglobins. The Akron Dental Society took 1,500 x-rays. There were 8,000 diabetic detection kits given out.

The Arthritis and Rheumatism booth was staffed by the following: Mrs. Roger Davis, Mrs. H. O. Musser, Mrs. G. H. Bischoff, Mrs. W. B. Houston, Mrs. W. H. Brown, Mrs. M. G. Wince, Mrs. C. F. Tatum, Mrs. Wm. M. Davis, Mrs. H. W. Allison, Mrs. M. C. Beyer, Mrs. P. C. Doran, Mrs. D. I. Minnig, Mrs. J. W. Parks, Mrs. Louis Sheinin, Mrs. E. L. Mollin, Mrs. W. A. Hoyt, Jr., Mrs. A. V. Gold, Mrs. A. P. Ormond and Dorothy Kotke, secretary to Doctor Roger Davis.

Mrs. Arthur Dobkin organized the Diabetic Detection booth and arranged for the following workers: Mesdames W. C. Robart, U. T. Jensen, D. J. Roberts, J. C. Damitz, G. R. Dochat, Wm. Davis, R. R. Pliskin, T. V. Gerlinger, W. C. Marsh, C. J. Paternite, R. M. Rees, E. F. Hellwig, A. I. Reaven, M. J. Gibans, A. W. Friend, R. J. Ferris, W. G. Kraus, J. W. Ferraro, a dentist's wife.

TRUMBULL

The March meeting was held at the Trumbull Country Club. A report was given on the Nurses' Recruitment contest for Senior High School students which is sponsored by the Auxiliary. A social hour followed the business session.

WASHINGTON

The Auxiliary entertained members of the Auxiliary to the Parkersburg Academy of Medicine at the March meeting. The program committee headed by Mrs. Edgar Northrup was in charge of arrangements. She was assisted by Mrs. G. E. Huston, Mrs. N. M. LaBarre, and Mrs. Richard Hille. Mrs. R. H. Sloan welcomed the guests and introduced Mr. and Mrs. William J. Garrison and Mrs. Harry Ezell of Columbus.

Mr. Garrison showed pictures of New Mexico with musical arrangements by Mrs. Garrison. Mrs. Charles Goodhand of Parkersburg, president of West Virginia State Auxiliary, was one of the guests.

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1. Rev. Gastroenterology 20:744 (Oct.) 1953; abstract in J. A. M. A., 153:1580 (Dec. 26) 1953.

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Attention Is Called to Provisions Of Ohio Use Tax Law

Reports indicate that officials of the Ohio Department of Taxation have been checking accounts of some physicians, apparently for the purpose of determining whether they have complied with provisions of the Ohio Use Tax Law.

The law is general and in no way discriminates against physicians. Its purpose is to protect Ohio merchants from discrimination and in principle imposes a tax on the same basis as the sales tax on purchases made outside of the State. Rule 102 of the Ohio Tax Commission applies specifically to physicians and dentists.

The following summary of the regulation is taken from the Annual Tax Roundup for physicians which appeared last in the December, 1953 issue of *The Journal*:

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department. **However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15, for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."**

Rule 102 of the Ohio Tax Commissioner applies specifically to physicians and dentists. It reads: "Physicians and dentists are the consumers of the various items of tangible personal property which they use in the rendition of their professional services and the tax will apply upon their purchase of all items of tangible personal property, including equipment. The tax does not apply to the fee for professional services rendered by physicians and dentists. If physicians and dentists apart from their professional services are engaged in selling, to the public such articles as medical supplies, mouth washes, dentifrices and the like, they are venders and must procure a vendor's license and collect the tax on all such sales."

Federal Court Cracks Down on Quack Diagnostic-Therapeutic Devices

Thirteen electrical devices which have been widely distributed for the diagnosis and treatment of serious diseases were barred from shipment in interstate commerce by an injunction decree entered recently in the Federal district court at San Francisco.

The Electronic Medical Foundation of San Francisco consented to the entry of the decree, which is also binding upon the officers of the Foundation and all persons in active concert or participation with them.

The Food and Drug Administration, U. S. Department of Health, Education, and Welfare, which initiated the injunction suit, estimates that there are about 5,000 of the devices now in the offices of various fringe practitioners throughout the country. The machines have been produced under a variety of trade names.

In addition to these machines the decree bans interstate shipment of "Blood Specimen Carriers" for use in a diagnostic machine, the Radioscope, which is maintained at the Foundation's offices in San Francisco. It also bans the shipment of any similar electrical devices for producing or measuring low-power radio waves or magnetic energy or any accessories or parts of such devices.

According to the injunction complaint, the Foundation's activities were divided in two major parts: The sale of a blood "diagnostic" service and the distribution of "therapeutic" devices. The diagnostic service was based upon the theory that any ailment can be diagnosed by measuring emanations from a dried blood spot on sterile paper.

The Government charged that the Radioscope was represented as a "tuning apparatus." This device is a box containing dials, lights, and wires, and a slot in which may be placed a specimen carrier of filter paper bearing dried blood of the patient. Metal plates connected with the box are held by a person who is designated the "reagent" and who is supposed to serve as a "detector" for the radiations allegedly emanating from the blood spot. The operator of the machine strokes the abdomen of the "reagent" with a plastic wand. If the wand "sticks" to a particular location, that is supposed to be a manifestation of an "electronic reaction," and the operator allegedly can determine from this the identity, kind, location and significance of any disease present.

Investigating the blood diagnostic service, Food and Drug inspectors found it was incapable of distinguishing the blood of animals or birds from that of man, or that of the living from the dead.

Widows in the United States now number about 7,500,000 and the total has been increasing by 100,000 a year, Metropolitan Life reports.

What To Write For

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

How Our Laws Are Made. Outline of the background and numerous steps in Federal lawmaking process, directed principally to the procedure involving bills introduced in the House of Representatives, noting such differences as may exist with regard to Senate bills. Catalog No. 83-1:H. Doc. 210, Superintendent of Documents, Government Printing Office, Washington 25, D.C., price, 15 cents.

Your Driving Costs. Do you know how much it costs you to own and drive your car? This report from the American Automobile Association based upon a cost accounting formula is interesting and informative. Available from your local auto club, or the Ohio State Automobile Association, 50 W. Broad St., Columbus 15.

Manual for Student Nurse Recruiters. Beginning with the organization of a careers committee, this handbook carries through the many activities of a year-round campaign. Available at 75 cents from National League for Nursing, Inc., 2 Park Avenue, New York 16, N.Y.

A Study of Union Health Centers. Data accumulated on a dozen such centers by the Committee on Medical Care for Industrial Workers of the American Medical Association. Available without charge from Council on Medical Service, American Medical Association, 535 N. Dearborn St., Chicago 10.

How to Choose and Use Nonfat Dry Milk. An Agricultural Extension Service publication for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at five cents. Catalog No. A1 68:227.

A Study of Multiple Screening Programs. Details of a survey of 22 multiple screening programs in various parts of the United States, including results of follow-up. Available free from the Council on Medical Service, American Medical Association, 535 N. Dearborn St., Chicago 10.

Vitamin and Mineral Content of Certain Foods as Affected by Home Preparation. A U.S. Department of Agriculture publication based on research by the Bureau of Human Nutrition and Home Economics, Agricultural Research Administration. Catalog No. A1. 38:628, Superintendent of Documents, Government Printing Office, Washington 25, D.C., Price, 40 cents.

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES
STARTING DATES

SURGERY—Surgical Technic, Two Weeks, May 17, June 7, July 26. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, June 7, August 9. Surgical Anatomy & Clinical Surgery, Two Weeks, June 21. Surgery of Colon & Rectum, One Week, June 7. Thoracic Surgery, One Week, June 7, Esophageal Surgery, One Week, June 14. General Surgery, Two Weeks, July 26. Fractures & Traumatic Surgery, Two Weeks, June 7.

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, June 7. Vaginal Approach to Pelvic Surgery, One Week, June 21.

OBSTETRICS—General & Surgical Obstetrics, Two Weeks, October 4.

MEDICINE—Two-Week Course September 27. Electrocardiography & Heart Disease, Two Weeks, July 12. Hematology, One Week, June 14.

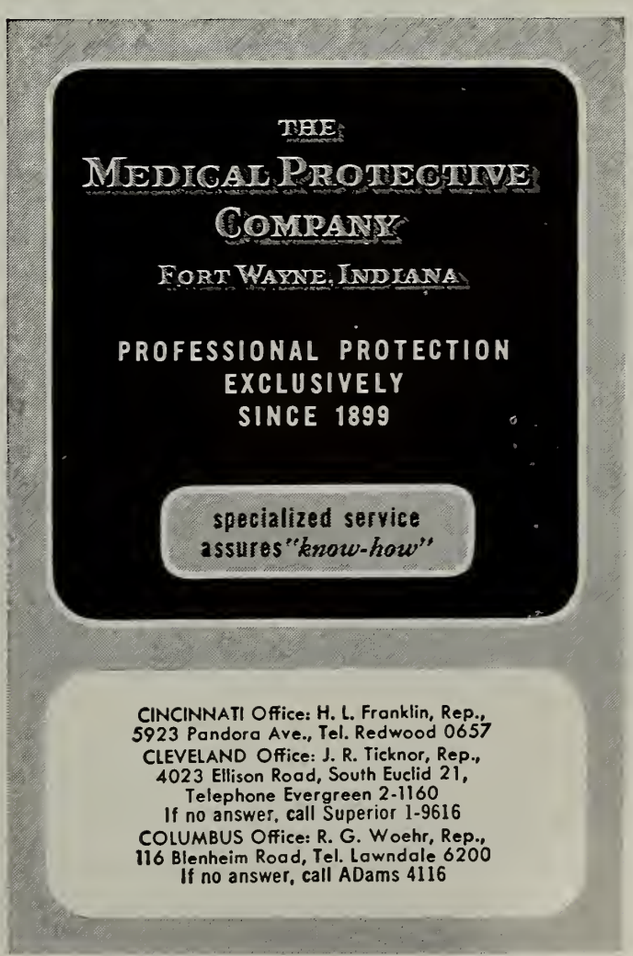
RADIOLOGY—Clinical Diagnostic Course by appointment. Clinical Uses of Radio Isotopes, Two Weeks, June 7. Radiation Therapy, by appointment.

PEDIATRICS—Cerebral Palsy, Two Weeks, June 14. Congenital & Rheumatic Heart Disease in Infants & Children, One Week, October 11 and October 18. Two Weeks, October 11.

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Polio Vaccine Tests Under Way In Two Ohio Counties

Poliomyelitis vaccine field tests were scheduled to proceed as previously planned in two Ohio counties—Montgomery and Richland, Dr. John D. Porterfield, director of the Ohio Department of Health, announced as this issue went to press.

First injections of the vaccine were scheduled to be given to approximately 18,000 children, whose parents have requested their innoculation, on Wednesday, April 28.

As this issue went to press, the vaccine was in the hands of the Ohio Department of Health, under bond. The Medical Advisory Committee was preparing to go over the protocol of each lot of the vaccine to make doubly sure that specified three-fold national safety tests had been complied with, Dr. Porterfield said.

Officials of Summit County—the third county originally scheduled to proceed with the tests—decided not to go ahead with them at this time because of the delay in receiving the vaccine and a complicated local polio situation. Summit County has had an unusually early season for polio in the past.

The Council of the Ohio State Medical Association, on April 11, reaffirmed its previous resolution (of December 3, 1953) voicing the cooperation and assistance of the Association to public officials in the field tests.

Action of The Council was in the form of approval of a previous public statement made by Dr. Paul A. Davis, Akron, President of the Ohio State Medical Association. Following a broadcast by Walter Winchell, who raised questions about the vaccine, Dr. Davis explained the position of The Council and expressed his conviction that authorities in charge of the program, including Dr. Porterfield, had the confidence of members of The Council, and that the safety tests would be carried out before any vaccine is released for public use.

In keeping with a national policy, gamma globulin will not be used in polio cases in the test counties, Dr. Porterfield said. It will be available for use in those counties for measles and hepatitis, he said. The g. g. program for polio will continue in other counties as outlined in the April issue of *The Journal.*

One change in the procedure for administering g. g. to polio contacts is in the dosage, Dr. Porterfield said. It is recommended that the dosage be increased from the former 0.14 cc. per lb. to 0.2 cc.

The eighth annual clinical and scientific conference of the Association for Physical and Mental Rehabilitation will be held at the Hotel Hollenden, Cleveland, June 28- July 2. Conference chairman is Mr. Earl B. Raymer, 130 W. 5th Ave., Berea, Ohio.

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FOR SALE: Excellent location in a thriving town, in rich farming and mfg. community; reason, retired. P. S. Bishop, M. D., Delta, Ohio.

FOR RENT: Five-room office space in physician's Building, 63 North 4th St., downtown Newark; private parking, elevator service; heat furnished; building occupied by physicians and dentists only; rent reasonable. Jesse J. Hedges, West Village Drive, Newark, Ohio; Phone 6216.

LOCUM TENENS for Cleveland, neighboring cities, Sept. '54, 1 mo., Ohio license. Completing first year residency Internal Medicine at University Hospital. State salary, living conditions. Write G. Seltzer, M. D., 419 N. State St., Apt. 5, Ann Arbor, Mich.

ACTIVE GENERAL PRACTICE: Good location in Cleveland; fully equipped, clean, air-conditioned offices, all available on lease for 3 to 4 years beginning July 1, 1954. Write Box 771, c/o Ohio State Medical Journal.

FOR SALE: X-ray equipment of deceased physician. 100 ma transformer and control, full wave rectified, with motor driven table. Not shock proof. Giles Wolverton, M. D., 970 Fidelity Bldg., Dayton 2, Ohio; AD 3941.

ASSISTANT WANTED: Opportunity for young man or young woman who has completed one year of internship, associate with diplomate in Ob., Gyn. City of 400,000, central Ohio. Work would be largely general practice, pediatrics, and obstetrics. This position is comparable to a general practice residency. Beautiful, roomy office; opportunity to specialize eventually. Pay is good, but if immediate financial return is your main interest you can probably do better elsewhere. Address Box 772, c/o Ohio State Medical Journal.

FOR RENT. Furnished office and home combination in Mansfield, Ohio, two blocks from the hospital. Excellent opportunity for young G. P. to get started with minimum outlay. Write: Alvin Bales, M. D., P. O. No. 3, Norwich, Vt.

FOR SALE: Gen. practice, Cleveland west side. Office in bank bldg. compl. equ. with x-ray, EKG, BMR, etc. Owner deceased. Box 774, c/o Ohio State Medical Journal.

WANTED: Young physician from Class A medical school with adequate hospital training for an office doing industrial work and general practice. An excellent opportunity for an ambitious young man. We have two positions, one for locum tenens and the other for a longer term. The pay will be satisfactory. 200 Republic Building, Cleveland, Ohio.

WANTED: Sandusky City & Erie County, Ohio, population 52,000 (small county) located on Lake Erie; (1) Physician. Health Commissioner. minimum salary $8,000, plus car expense; (2) Two P. H. Staff Nurses, minimum salary $2,880 plus car expense. Health Department, Sandusky City and Erie County, Sandusky, Ohio.

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National Tuberculosis Meetings To Be Held in Atlantic City

The 50th Anniversary Meeting of the National Tuberculosis Association—first of the voluntary groups organized on a nationwide basis to fight a specific disease—and the 49th Annual Meeting of its medical section, the American Trudeau Society, will be held May 17-21 in Atlantic City. The Ambassador, Chelsea, and Ritz Carlton Hotels will be used.

The general theme of the anniversary meeting will be "The Challenge of the Future." There will be a number of general sessions, the first of which will be Monday afternoon.

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1. Thorn, G. W., *et al.*, *New England J. Med.* **248**:632, April 9, 1953.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Opiate Addiction, by Abraham Wikler, M. D., ($3.00. *Charles C. Thomas Co., Springfield, Ill.).* An excellent series of lectures on this popular, but not well understood problem covering the cultural, economic, sociological, psychological and chemical factors which contribute to cause, course and treatment of this addiction. The author is the well-known, experienced neuropsychiatrist at the U. S. Hospital at Lexington, Kentucky, for addicts.

Essentials of Medical Research, by Wallace Marshall, M. D., ($3.00. *The Vantage Press, Inc., New York 1, N. Y.),* is a plea for every physician to do some research pointing out that, contrary to current belief, well-staffed laboratories are convenient, but not essential. If most of us would take up research as a hobby instead of painting, stamp collecting, or golf, much good would accrue to us and to the world, and we would have found more fun. Your reviewer has been urging young men to take advice of this kind to heart.

Health Yearbook 1953, by Oliver E. Byrd, M. D., ($3.50. *Stanford University Press, Stanford, Calif.).* Identical to that of ten previous volumes. An essential book of integrated abstracts to health educators.

Living With a Disability, by Howard A. Rusk, M. D., and Eugene J. Taylor, ($3.50. *The Blakiston Company, Inc., New York 22, N. Y.).* A book of encouragement with 275 cuts to emphasize the art of living under physical handicaps. From the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center.

Principles of Medical Ethics, by John P. Kenny, O. P., Ph. D., ($3.25. *The Newman Press, Westminster, Maryland).* A detailed handbook of moral theology for doctors, nurses and medical students.

Devils, Drugs and Doctors, by Howard W. Haggard, M. D., ($0.35. Cardinal Edition, *Pocket Books, Inc., New York 20, N. Y.).* A pocket reprint of this interesting and popular book.

Conferences on Drug Addiction Among Adolescents, ($4.00. *Blakiston Company, New York 22, N. Y.).* The sub-committee on Public Health with the help of The Josiah Macy, Jr. Foundation, sponsored this conference at the height of the swing of these addicts.

Forensic Psychiatry, by Henry A. Davidson, M. D., ($8.00. *Ronald Press, New York 10, N. Y.),* written as a guide for physicians. Anyone who examines or treats the human mind or attempts to diagnose its vagaries must expect to be asked, sooner or later, to give testimony before some tribunal—hence, becomes, whether he likes it or not, an expert witness. In preparation for this event, such a physician will find this manual most helpful.

Individual and Community Health, by William W. Stiles, M. D., ($6.00. *Blakiston Company, New York 22, N. Y.).* A college text on preventive medicine that is persuasive.

Nursing History, by Minnie Goodnow, R. N., ($3.75. Ninth Edition. *W. B. Saunders Co., Philadelphia 5, Pa.),* a comprehensive essay in 15 chapters and 425 pages covering all steps chronologically from Mosaic law to 1951, in all climates and among all peoples.

School Nursing in The Community Program, by Marie Swanson, R. N., ($5.00. *The Macmillan Company, New York 11, N. Y.),* is a portrayal of nursing as it is most effectively carried out in the schools today. It will serve well the interests of physicians, nurses, health officers and school administrators.

Medical Ethics, by Charles J. McFadden, O. S. A., ($3.75. Third Edition. *F. A. Davis Company, Philadelphia 3, Pa.),* has become a classic in its field, presenting as it does, the moral law of the church as applied to the care of the sick.

Disability Evaluation, by Earl D. McBride, M. D., ($15.00. Fifth Edition. *J. B. Lippincott Co., Philadelphia 5, Pa.).* Physicians will find this, as they have the previous four editions, of great help in giving an opinion as to the degree of disability and the permanency of the injury done to the working-man.

Health and Fitness, by F. L. Meredith, M. D., L. W. Irwin, Ph. D., and W. M. Staton, Ed. D., ($3.20. Second Edition. *D. C. Heath & Company, Boston 16, Mass.),* written from the viewpoint of what the student needs.

Medical Schools in The United States at Mid-Century, by John E. Deitrick, M. D., and Robert C. Berson, M. D., ($4.50. *McGraw-Hill Book Co., Inc., New York 36, N. Y.).* A comprehensive, formal report of the Survey of Medical Education. Among the conclusions drawn is that over-expansion of medical services, research programs, and training programs for personnel to deal with sickness is dissipating the educational energies of the schools. Another, and equally important, conclusion is that many administrative officers are still under the illusion that the medical student is the major if not the only item of educational expense, whereas in reality medical schools assume the obligation to participate in the edu-

cation and training of all the other members of the team opposing disease. The result of all this points out, as your reviewer has been insisting for years, the need for a realistic budget to show how much is spent on: (1) Education of Medical Students, (2) of Other Members of the Team, (3) Research, and (4) Care of the Sick. Once these figures were available the cost of medical education could be computed. As it is, no one knows what it costs to educate a medical student. Someday some legislator or trustee is going to ask.

Tularemia, Weather, and Rabbit Population, by Ralph E. Yeater, and David H. Thompson. *Bulletin of the Illinois Natural History Survey,* Volume 25, Article 6, *Urbana, Ill.* In the twenty-four year period beginning in 1926, Illinois has had twice as many cases of tularemia reported as any other state. The human rate of this disease in this state seems to be determined both by the temperature at the opening of the hunting season and by the total number of rabbits in the area. The practical point of this study is the recommendation to delay the opening of the hunting season until after December 1.

Nursing of Children, by Gladys Sellew, Ph.D., and Mary F. Pepper ($3.75. Seventh Edition. *W. B. Saunders Company, Philadelphia 5, Pa.*), takes up the subject by age groups, showing the normal characteristics of growth and development and then the nursing care of these same children when attacked by the diseases common to the age group.

Stress and Disease, by Harold G. Wolff, M.D. ($5.50. *Charles C. Thomas, Publishers, Springfield, Ill.*). This essay seeks to extend the concept that DISease is the resultant of unfavorable forces in the physical environment overcoming the favorable forces without and within Man by emphasizing past experiences as a major factor. It suggests, therefore, that Man, confronted by threats, especially as they involve values and goals, initiates responses inappropriate in both kind and magnitude. Such reactions, integrated for one protective purpose, and thus inappropriately used for another, can damage or destroy Man.

The Microbiological Assay of The Vitamin-B Complex and Amino Acids, by Eustace Cecil Barton-Wright ($4.00. *Pitman Publishing Corp., of New York and London*). This book is a welcome assessment of the recent advances in this field and of the validity of methods and computation. Each assay is described in detail in such a manner that the procedure will be clear to even a beginner.

Salt and The Heart, by Edward T. Yorke, M.D. ($3.45. *Drapkin Books, 36 East 19th St., Linden, N.J.*), presents a fundamental discussion of the principles underlying the low-sodium diet and the problem of salt accumulation in the body. Man can cope with his perversion for salt until he shows a tendency to accumulate it because of heart failure, pregnancy, and certain other conditions. In our efforts to combat salt accumulations in the body, Dr. Yorke insists that the control of sodium in foods offers the best results and is the most natural means at our disposal. Your reviewer has always insisted that a normal person should stop perverting the use of salt, as a preventive measure.

An Atlas of Pelvic Operations, by Langdon Parsons, M.D., and Howard Ulfelder, M.D., Illustrated by Mildred B. Codding, M.A. ($18.00. *W. B. Saunders Co., Philadelphia 5, Pa.*). This is an illustrated guide to the work of the school of gynecologic surgery developed by Joe Vincent Meigs at the Harvard Medical School. A book of reference for the gynecologist and his house staff.

Scientific Explanation, by Richard B. Braithwaite ($8.00. *Cambridge University Press, New York 22, N.Y., and Cambridge*). A study of the function of theory, probability, and law in science. Its primary purpose is to examine the logical features common to all science. Every science begins by inventing an hypothesis from which are deduced particular consequences to be tested by experiment and observation. The author shows how the implications of this process may throw light upon seemingly mysterious features and should resolve many of the difficulties that philosophers have found in them. Your reviewer is afraid that most of us physicians are a little vague on such fundamentals as the function of mathematics and probability in science, of the relation between scientific theories and "models" for them, and of teleological explanations. If you feel you are, here is a clear exposition which you might study.

Sacral Nerve-Root Cysts, by I. M. Tarlov, M.D. ($6.50. *Charles C. Thomas, Publishers, Springfield, Ill.*). This book describes in detail another cause of sciatic and cauda equina syndrome. In this condition surgery offers a good chance of a successful cure.

You and Your Inheritance—Science for Better Living, by Paul F. Brandwein, Leland G. Hollingworth, Alfred D. Beck, and Anna E. Burgess ($3.16. *Harcourt-Brace & Co., New York and Chicago*). A modern text with graphic illustrations and a clear text on Man and his important environmental factors affecting his life and longevity.

Gandhi: His Life and Message for the World, by Louis Fischer ($0.25. A Signet Key Book, *The New American Library of World Literature, Inc., New York 22, N.Y.*). This is a warmly human life-story of one of the world's great men which in reading will do all of us in our present-day frustration good.

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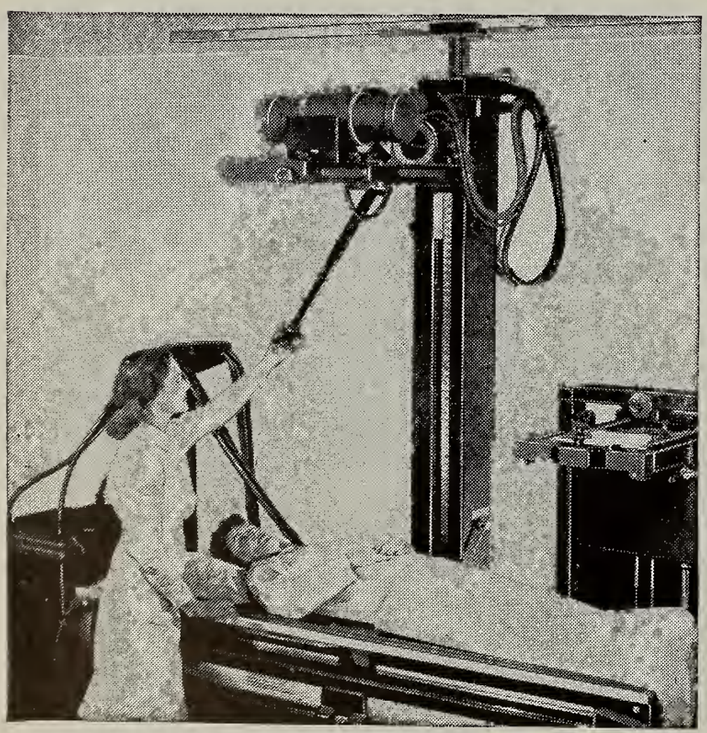
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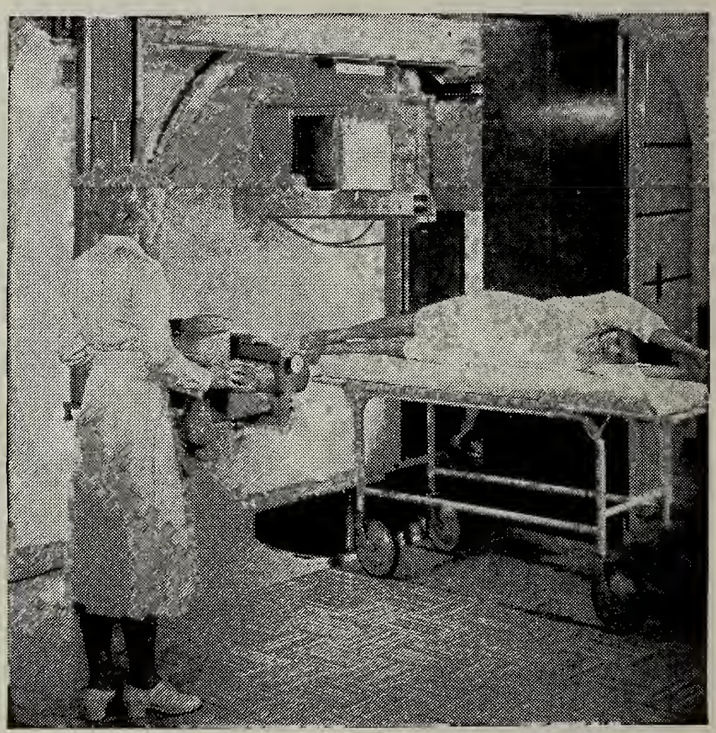
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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 50 June, 1954 No. 6

JONATHAN FORMAN, M. D., *Editor*

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Ritter's Disease With Recovery

EARL E. SMITH, M.D., and IRVING L. SCHONBERG, M. D.

RITTER in 1878[1] first described the disease which bears his name. In his original paper he reported a rare exfoliating disease of the skin of nursing infants. He believed it to be of pyogenic origin. The prognosis was unfavorable in 50 per cent of the cases, and the outcome depended largely upon the strength and vitality of the child.

Since Ritter's first description of this disorder, many cases of similar character have been reported. The etiology of Ritter's disease has never been definitely established. In a paper by Kendall and Aegerter,[2] four possible causes were suggested:

(1) Local infection;

(2) Irritation of central vaso-motor apparatus;

(3) An increase of normal physiologic desquamation;

(4) Nutritional disturbances of the vascular layer of the epidermis.

In spite of the fact that various organisms were removed from the skin in a series of cases, he felt that death was due to an aberration in the normal function of the skin.

Captain Arnold Widerman[3] reported a case of an eight day old Negro boy, with death on the thirty-first day, from Ritter's disease. Infection with Staphylococcus albus was prominent throughout. Culture of the blood and of the bullae on the baby, the discovery of a retroperitoneal abscess at autopsy and an abscess on the breast of the mother following nursing of the infant, pointed to infection as the etiologic agent.

According to Captain Widerman, trauma played an important part, since bullae could be induced by constant pressure of dressings and repeated friction of one portion of the body on another. He also felt that there was some deficiency in the epidermis and that the prognosis depended chiefly on the extent of actual and potential loss of cutaneous surface.

Perhaps one of the best papers of recent years has been a report of Lee, Wilson et al.[4] who reported an epidemic of pyodermas in newborn infants and classified Ritter's disease as a fulminating systemic type of infection, and agreed with the staphylococcic etiology. The following is a report of a case which developed rapidly, presumably around an infected circumcision. The patient was treated early and vigorously with complete recovery.

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REPORT OF A CASE

The patient, a white male, one of twins, was delivered by cesarean section because of transverse position with vaginal bleeding, probably due to premature separation of the placenta. The neonatal course in the hospital had been normal. He was circumcised at three days of age, and sent home on the fourth day. At that time the mother noticed several crusted lesions involving the glans penis and suprapubic area. On the morning of the fifth day, the patient developed an eruption around the mouth which by

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Submitted August 29, 1953.



Figure 1

afternoon involved much of the cutaneous surface. He was hospitalized on the same day.

The infant presented on the face, neck, and extremities large areas of denudation and erythema. There was some fissuring at the angles of the mouth. There was edema and erythema in several of the nail folds. There were a few crusted areas with slight exudation involving the glans penis, and several small exudative lesions were noted in the pubic area. There were no bullae. The epidermis could be removed by friction (Nikolsky's sign). See figure 1.

Laboratory Data: Hemoglobin 17.6, white blood count 5000; Differential: neutrophils 48, lymphocytes 46, monocytes 2, eosinophils 4; Blood culture, no growth. Epidermal culture, slight growth of Pneumococcus hemolyticus, Staph. aureus, M. catarrhalis and E. coli.

Course in hospital: The temperature remained normal throughout the entire period of therapy. The patient was isolated and a strict sterile routine was established. The patient was placed in a heated tent, unclothed, with sterile sheets and bed clothes. Nursing and medical personnel wore sterile gowns, gloves and masks. Streptomycin 75 mgm. was administered twice daily and crysticillin® 150,000 units daily. Local therapy consisted of potassium permanganate baths, aureomycin ointment and later terramycin® and bacitracin ointment.

During the entire course of therapy the patient was irritable and cried when touched; pressure on various areas of the body seemed to produce great discomfort, and sedation was obtained by means of elixir phenobarbital. The patient was discharged six days after admission to the hospital, completely recovered.

Follow-up: It has now been two months since the episode. The infant gained weight and there is no evidence of exfoliation.

DISCUSSION AND CONCLUSION

Although the etiology of Ritter's disease has never been definitely established, we feel that infection of the circumcision site was the primary factor in producing this case of exfoliative dermatitis. The fact that the disorder occurred in one of twins is of particular interest, and it is felt that early detection of the disorder prevented the cross infection in the other infant.

Early recognition, followed by vigorous therapy, which should include the administration of antibiotics, parenterally, as well as adequate local therapy, is essential for effective recovery.

From the standpoint of epidemiology, we agree with Lee and Wilson that a thorough search should be made in nurseries where pyodermas are detected, regardless of type or severity. This should include cultures of the nose and throat of nursing personnel. Infections prevalent on the skin of those in contact with nursing infants should be treated, and during therapy these should be eliminated from the nursery. It is possible that Ritter's disease is a toxic manifestation of a pyoderma resulting in exfoliation.

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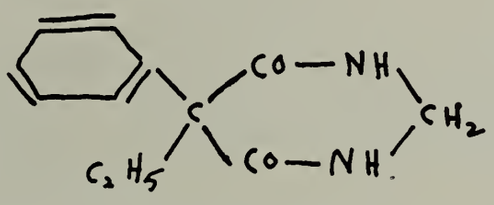
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The Effect of Mysoline® in Previously Uncontrolled Epilepsy

GERALD R. NOWLIS, M. D.

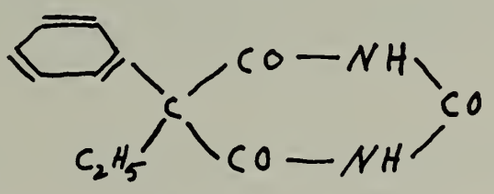
MYSOLINE® (5-phenyl-5-ethyl-hexahydropyrimidine-4:6-dione), an anticonvulsant drug first introduced in 1949,[1] is a white crystalline substance, chemically stable, only slightly soluble in water, and almost tasteless.* Animal experimentation has shown that it compares favorably with other commonly used anticonvulsants in the prevention of grand mal seizures.

Studies on its toxicity are still in progress. Thus far no hematologic or renal disturbances have been noted in human beings but there is an occasional report of a morbilliform rash apparently consequent upon therapy.[2, 3, 4]



MYSOLINE

The similarity between mysoline® and its parent substance, phenobarbital, can be seen by a glance at their chemical formulae.



PHENOBARBITAL

Thirty-four patients have been tried on mysoline® during a period of 14 months. Two have drifted away from the clinic in this period and four others have their seizures so irregularly that it is not yet possible to make a statement about the effect of mysoline® on their attacks. Six are so deteriorated that they are unable to supply even the most rudimentary information concerning the number and severity of seizures; these were given the medication solely because it was suspected that their epilepsy was uncontrolled and it was hoped that a measure of relief might be obtained for them with this newer agent. The remaining 22 patients have been followed for from 4 to 14 months and it is on these that attention will be focussed.

The 22 patients on which this report is based were all clinic outpatients in a large municipal hospital. Almost without exception they came from the lowest economic group. Their age range was from 16 to 57 years, the mean being 34.1 years. The mean duration of convulsive seizures was 19.7 years. Eleven were female, 11 male.

The single criterion used in the selection of these cases was that the patient should have been tried on the standard medications and these found wanting. One might say then that the series was "loaded," in the sense that the patients were long-standing epileptics who had failed to respond to the usual measures. It should be mentioned that the incidence of mental deficiency, chronic alcoholism, psychopathy, and poor adjustment to life situations was obvious in the group.

The writer treated and followed all of the patients personally. This provided a constancy of observation and reporting but at the same time allowed for slanting of findings without awareness of doing so. Objectivity was sought for, but it is hardly conceivable that the patients should not have sensed that I was particularly interested in them since previously most of them had not been seen by the same physician for more than four or five successive clinic visits. All realized that they were being tried on a drug which they had not used before, but the fact that it was still under investigation was not suggested to them.

It is difficult to refrain from doing simple psychotherapy with epileptic patients and this again introduces a complicating variable which of necessity shifts with each new change of physician. The interviews, which were at two to four week intervals, did not center around the number of attacks which the patient had had since his last visit but rather were concerned with the individual's total adjustment, this being the usual line of approach in the neurology clinic at the Cincinnati General Hospital. However, each time

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*"Mysoline" is the registered trade-mark of Imperial Chemical (Pharmaceuticals) Ltd., represented in this country by Ayerst, McKenna & Harrison, Ltd.

the patient was seen the type and number of seizures were enquired about and recorded. In eliciting side-effects no suggestions were made to the patient but rather he was encouraged to tell how things had been going.

Eight of our cases were considered to be idiopathic epilepsy, 5 were post-traumatic, and 9 were thought to be secondary to diffuse cerebral pathology. The latter grouping represents a hodgepodge in the sense that while some are clearly postencephalitic, in most instances we have no verifiable history, no discernible etiology, and nothing more on which to base our opinion than cerebral atrophy as demonstrated by pneumoencephalography, or diffuse cerebral dysrhythmia as shown by electroencephalography, or both.

RESULTS

Of the 8 with idiopathic grand mal epilepsy, 2 had associated petit mal seizures and 2 others psychomotor fits. Of these 8, all showed improvement with respect to their grand mal attacks, this varying from, at the least, a 50 per cent reduction to what appears at the present time to be complete control. Parenthetically it should be said that patients from all three groups have volunteered the information that when they do have seizures these are considerably "lighter"; we interpreted this to mean that some of the grand mal attacks are being converted into partial seizures. Both patients with petit mal noted an increase of these minor seizures, one to the point where attacks were occurring so frequently that he stopped taking mysoline® and within two days experienced relief. Both of these patients attained good control of their grand mal seizures while on the drug.

At this time it is impossible to present any critical evaluation of the effectiveness of mysoline® therapy on psychomotor epilepsy. Because it is so difficult to collect objective information on the particularities of these episodes it can only be said that there has been some diminution in the number of these seizures.

The group of 5 persons with post-traumatic epilepsy represents our best therapeutic result. All had generalized convulsions, some of which started with a jacksonian march but none remained localized. All are now completely controlled.

Four of the group of 9 with diffuse cerebral pathology had a decrease of 50 per cent or more in the incidence of their seizures. None were completely controlled. Four were unimproved. One had so severe a reaction to the initial dose that he refused to try it again. Untoward reactions to mysoline® will be discussed below.

DOSAGE

Eleven patients have been handled on mysoline® alone and 11 in combined therapy, the goal being to dispense with other anticonvulsant drugs whenever possible but retaining them if it became obvious that mysoline® alone would not be adequate. Only those in the post-traumatic group have been consistently well controlled on mysoline® alone. Four of the idiopathic epileptics were optimally managed without additional medication; this occurred in only 2 of the third group in which there was diffuse cerebral involvement.

Dosage varied from 0.50 to 2.0 grams per day. When a patient failed to respond well to 1.5 grams per day we found no improvement with further increase in dosage, even in the absence of side effects.

It is perhaps significant that no patient has been completely controlled on combined medication although a number have certainly been improved. This might indicate that mysoline® has a certain specificity or, then again, it might mean simply that the less severe cases have been skimmed off with this new medication and that the hard core of intractables is smaller but nonetheless extant.

SIDE EFFECTS

Emotional changes were the most striking of the side reactions noted. Three patients, all of the post-traumatic type, showed a remarkable sense of well-being which one hesitates to call euphoria because it developed concomitantly and persisted with the control of seizures. Associated with this there was renewed interest in work and, in fact, these three people have become regularly employed.

Four patients developed a psychological reaction against mysoline® which amounted almost to personification of the drug with a great and abiding hatred for it. One individual manifested this reaction after the initial dose of 0.25 grams, the others after several weeks to months when total dosage had reached 0.50, 0.75, and 1.5 grams. With this reaction, none of them would consider taking even one more tablet. These patients reported that they felt weak, drowsy, ineffectual, and "sapped" of their energy. The man who had such a severe reaction to 0.25 grams was unable to function adequately for 60 hours afterward. One might postulate that deep feelings of helplessness were aroused in these persons, their antipathy for the medication being a consequence of this.

The grand mal and partial seizures of one postencephalitic patient were much decreased with mysoline® supplemented by dilantin® and phenobarbital; however, after some 4 to 6 weeks during which mysoline® was being increased and the other drugs reduced, the patient began to engage in wild, noisy, and irrational behavior. When mysoline® was withdrawn, this remitted in from 24 to 48 hours, but the patient simultaneously went into status epilepticus. Since then a "sensitivity," if one may call it that, has developed and the patient becomes unruly and

impossible to handle if a single tablet of mysoline® is given. This has been tried several times and the mental reaction invariably recurs.

Excluding the above-mentioned cases, four patients complained of mild drowsiness and weakness, one noted a persistent but mild ataxia and dizziness, and one remarked on constipation and urinary retention. None of these necessitated discontinuance of the drug. In those who complained of drowsiness and weakness, the symptoms abated when the dosage was decreased.

SUMMARY

In summary, there would appear to be little question that mysoline® has an anticonvulsant effect in man. An arduous trial to which a drug of this sort can be put is that with which this study was mainly concerned, namely its effect on patients previously uncontrolled in a large epileptic population. There are pitfalls, however, in this connection, since in a large clinic population such persons are likely to be given short shrift, and the lift that they may experience with the continuing attention of an interested physician may be critical. Benefit by reason of doctor-patient relationship must not be discounted, as has been the tendency in this modern era of medical therapy.

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Use of Vitamin B_{12} in Treatment Of Diabetic Neuropathy

The use of vitamin B_{12} and of the extract of the livers of pregnant mammals is purely empiric with no particular rationale. Although the use of vitamin B_{12} in the neuropathy of Addisonian anemia is well established, the pathology is not the same as that in diabetic neuropathy.

In pernicious anemia the large heavily myelinated neurones which conduct motion and position sense are involved, in contrast to the small poorly myelinated neurone in diabetic neuropathy. Vibratory sensibility is first affected, and pain is rarely a significant complaint in pernicious anemia while it is extremely common in diabetic neuropathy. In pernicious anemia, in addition to the peripheral neuritis, there is a characteristic lesion in the posterior and lateral columns of the spinal cord. Such a lesion is not present in the neuropathy of diabetes.—Sidney Davidson, M.D., Lake Worth: *J. Florida M.A.*, 40:717, April, 1954.

KEEPING UP WITH MEDICINE

• HUMAN children, dogs, and poultry are prone to rickets, subsisting upon any diet which is deficient in vitamin D, although their susceptibility may certainly be influenced by dietary modification, such as the presence or absence of cereals containing phytic acid.

* * *

• IT SEEMS safe to assume that the animal viruses differ from bacteria in their manner of reproduction.

* * *

• ALLERGIC SENSITIVITY develops during convalescence from a number of virus infections. This state can usually be demonstrated by the intracutaneous injection of heat-killed virus preparations.

* * *

• DERMATOPHYTIDS are secondary eruptions occuring in specifically sensitized individuals as a result of the hematogenous spread of fungi or their allergenic products from a primary focus.

* * *

• GAMMA GLOBULIN appears to exhibit activity in the prevention of mumps, provided that it is given shortly after exposure to infection.

* * *

• THE COMPOSITION of the diet affects both the types and the numbers of the intestinal microorganisms.

* * *

• LOCAL ADMINISTRATION of aureomycin is held to be beneficial in herpes labialis, herpetic stomatitis, and keratitis perhaps because of the control of secondary invaders.

* * *

• IT SEEMS that the process by which the chin of Man developed is to be considered a part of the general adaptation of the primate body to the upright posture and locomotion.

* * *

• MULTIPLE SCLEROSIS may cause dizziness and it may be the only complaint. Here the picture is similar to that described as acute toxic labyrinthitis.

* * *

• IN RECENT DECADES, biochemical studies have indicated that large amounts of fluid in the abdomen may be properly related to metabolic deficiencies or abnormalities.

* * *

• THE BELIEF that some diseases are of miasmatic origin goes far back into antiquity and is not without its influence even today. Pollution of the air with noxious vapors was supposed to be the cause of plagues. In various forms this concept dominated the minds of those physicians who accepted the authority of Hippocrates and Galen. After the Black Death another very ancient concept came to the fore in Contagion.—J.F.

Measles Encephalitis

A Pediatric Review

LOUISE W. RAUH, M.D.

THE most serious complication following measles is encephalomyelitis or encephalitis. The incidence of this complication varies from epidemic to epidemic. It has been reported as frequently as one case of encephalitis or encephalomyelitis for each 600 cases of measles and as rarely as one in 3,000 cases. Measles encephalitis is more likely to occur among children suffering from severe attacks of measles than among those with mild attacks and is less frequent following modified measles than following the natural disease. There are, however, no available statistics on the incidence of both encephalitis and encephalomyelitis following modified measles.

Odessky and his co-workers[1] reviewed 590 cases of measles encephalitis and encephalomyelitis reported previously in the literature. The mortality rate was 15 per cent. Of those recovering from the acute illness, a minimum of 40 per cent were found to have sequelae.

Fox et al.[2] reviewed 77 cases of measles encephalomyelitis seen over a 25 year period (1927-1952). Twenty-two (28.6 per cent) of these patients died.

The age range of this group of patients was from 5 months to 32 years with 62.3 per cent occurring in children aged 4 through 7 years. The time of onset of symptoms varied from several hours to 9 days after the appearance of the rash, with 47 per cent of the patients developing them 3 to 4 days after the rash appeared. Coma or convulsions or both occurred in 68 per cent of those who died.

EARLY DIAGNOSIS

These authors pointed out one sign, often overlooked, which if observed may lead to the early diagnosis of involvement of the central nervous system in measles. In 74 per cent of their cases sudden cessation or depression of the typical measles cough initiated the onset of encephalitis. The cough reflex depends upon stimuli from the respiratory epithelium passing along the different fibers of the vagus nerve through the nucleus of the tractus solitarius and from there along the descending fibers of the spinal primary motor neurones with final discharge to the diaphragm, the intercostals, the abdominal muscles and the glottis. In measles encephalomyelitis, involvement of the tractus solitarius breaks this reflex arc and sudden cessation of the cough results.

Fox and his co-workers[2] warned against the use of medication containing codeine to depress the cough in measles patients. They described a group of patients diagnosed measles encephalomyelitis who exhibited convulsions, lethargy, vomiting, nuchal rigidity, cyanosis and fever. In all patients, the spinal fluid examinations revealed no abnormalities. Within 24 hours following oxygen and helium therapy these patients recovered. Anoxia following prolonged administration of codeine was thought to have been the basis of these symptoms.

USE OF GAMMA GLOBULIN

Odessky and his confreres reported the effective use of large doses of gamma globulin in measles encephalitis and encephalomyelitis. The goal of therapy in this disease is the reduction of mortality rate and the reduction of the incidence and severity of sequelae.

They treated a total of 41 cases of post measles encephalitis; 14 received no gamma globulin in the acute phase of the disease, 12 patients were given 4-16 cc. of gamma globulin in the acute phase (a total dosage of from 0.07 to 0.30 cc. gamma globulin per pound of body weight). The third group, comprising 15 patients, received 20 cc. or more gamma globulin in the acute phase (a total dosage of 0.43 to 1.1 cc. per pound of body weight). The gamma globulin had been obtained from pooled normal human plasma and it was administered intramuscularly.

The 15 patients receiving the largest dosage of gamma globulin were the most critically ill and among them no deaths occurred, there was a greatly reduced incidence of sequelae and a reduction in severity of the sequelae. In this group of patients the neurological symptoms resolved very rapidly, the temperature, pulse and respiration returned to normal sooner than in those receiving smaller doses or no gamma globulin and the hospital stay was shorter. The percentage of patients who recovered without any apparent residual symptoms was highest in this last group.

A total dosage of one cc. of gamma globulin per pound of body weight was recommended. The total dosage of gamma globulin should not be

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Submitted March 26, 1954.

less than 30 cc. in younger children because of the increase in metabolic rate. In instances when the temperature rises above 103° (rectal) an additional 10 cc. of gamma globulin should be added to the total dosage for children 6 years and younger and 20 cc. should be added to the total dosage for those over 6 years of age. Injections should be started as soon as the first sign or symptom of involvement of the central nervous system appears. The total dosage of gamma globulin should be given within a period of 36 to 48 hours after symptoms appear.

DOSAGE SCHEDULE

The following dosage schedule was recommended:

a. Total dosage 50 cc.
   20 cc. on admission to hospital
   20 cc. 12 hours later
   10 cc. 24 hours after second injection.

b. Total dosage 80 cc.
   30 cc. on admission to hospital
   20 cc. 12 hours later
   10 cc. 12 hours after second injection
   10 cc. 12 hours after third injection
   10 cc. 12 hours after fourth injection.

In dehydrated patients large doses of gamma globulin may cause a shift in osmotic pressure with subsequent elevation in temperature. Correction of the dehydration should be begun before the administration of the gamma globulin and the gamma globulin should be given in smaller doses at more frequent intervals.

Behavior disturbances following measles encephalitis and encephalomyelitis are common sequelae. Meyers and Byers[3] studied 16 children intensively and carried out frequent psychologic evaluations and guidance instruction over periods ranging from 14 months to 6 years. These studies showed that abnormalities of mental functioning could be demonstrated in a very high proportion of children after neurological and electroencephalographic evidence of the disease had cleared. In about one-third of the children, easy fatigability of intellectual function, defects in attention, defects in perceptual and spatial organization and defects in learning capacity tended to persist for months and in some instances permanently.

Patients with short, acute courses of the disease fared better than those with prolonged courses. When the psychologic defects persisted, inability to acquire new knowledge and adaptation produced a relative intellectual deterioration over the years. The child's inability to live up to the expectations of home, school and society produced emotional stress which was expressed by a retreat into himself or aggressive rebellion. A plan of life should be evolved which would make the necessary concessions to the child's disabilities and allow him emotional ease during the long period of recovery so that the eventual resumption of his responsibilities may be made easier.

The mother should give the preschool child emotional support and affection; and show patience especially during the period of toilet training, of learning to dress himself, and during the development of other habits. The school child should be given a home teacher for a period of a year or more and if this is not possible, repetition of the previous grade on a modified basis may be helpful.

The age at the time of the attack of encephalitis influenced the outcome. Older children, because of their more elaborate foundation of learning, were more likely to remain competitive in spite of incomplete intellectual recovery. This was not so in the younger child who must acquire the most fundamental learning with defective tools.

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Recent Dermatologic Hazards In Industry

Prior to the advent of the Diesel type of locomotive, there was only an occasional case of occupational dermatitis among workers in railroad machine shops and roundhouses. Workers are now exposed to lubricating oils, fuel oils, radiator cooling fluid and solvents. Of these, the radiator cooling fluid has been the most troublesome. This fluid contains an anti-corrosion compound, Nalco No. 38, which is a mixture of chromates, dichromates, and strong alkalies, which are primary skin irritants in strong concentration and can produce sensitization even in dilute solutions on repeated exposures.

Chronic chrome ulcers of hands, tongue oral mucosa and nasal septum have been recognized for many years and need no further comment at this time. However, epidermal hypersensitivity as the result of industrial contact with chromates is of paramount importance to industrial physicians, dermatologists and general practitioners. Sensitivity develops after a comparatively long period of exposure. All patients with chromate dermatitis showed positive patch tests to samples of radiator fluid and to 0.25 per cent sodium-bichromate solution.

Unfortunately, this eruption responds rather slowly to therapy, and despite avoidance of the specific sensitizing substances, recovery is very slow and the dermatitis quite persistent. A 3 per cent BAL (dimercaprol®) ointment has been recommended for local application in chromate dermatitis by some authors.—L. F. Weber, M.D., Chicago; Discussion by Dr. Frederick J. Szymanski, Chicago: *Illinois M.J.*, 105:17, January, 1954.

Realism and Unrealism in Psychotherapy

GERHARD HOFFMANN, M. D.

A. REALISTIC PSYCHOTHERAPY

WHAT is psychotherapy? In the broadest sense: a psychological procedure by which an influence is exerted by one person on another with the aim of improving the latter's general functioning to a point where well-being is increased and feelings of anxiety, dejection, or despair are lessened or eliminated.

In the same measure as either well-being or dejection may be based on either realistic or unrealistic notions which an individual may have developed about himself and about his position in his environment, there are, also, both realistic and unrealistic methods of correcting states of anxiety and of promoting well-being.

When we talk of realistic and unrealistic notions which individuals may hold about themselves, we are thinking primarily of the fact that people may either underestimate or overestimate their abilities, gifts, talents, and potentialities. Although we usually find both these tendencies in the same individual, we can yet distinguish between two types of persons, namely between those who are habitually more inclined to overestimate their qualities and those who are habitually more inclined to underestimate them.

NEUROTIC ANXIETY AND ITS CAUSES

In those people who are more ready to underestimate their own strength, we are likely to find a tendency to react habitually to all obstacles which they may encounter during any kind of task with feelings of profound anxiety and dejection, a tendency which stands in the way of their achieving actual or full success in life. An individual of this type will also be inclined to over-react with anxiety to singular traumatic experiences, as he will tend to overestimate their significance and their potential negative consequences for his well-being.

In an extreme instance of this kind, the individual may find himself plunged into deep depression, a reaction that will appear incomprehensible to an outsider who may have a better appreciation of the individual's real qualifications than he himself is able to afford. Altogether, we will say that in such individuals there is a primary tendency to distort unrealistically their position in the world in a negative sense. They are the black prophets, the pessimists, the people who cannot see themselves succeed, as they are completely unable to believe in their own strength and in their ability to master life and who therefore find themselves constantly defeated.

Submitted September 21, 1953

The Author

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We have found that individuals thus afflicted suffer from a deep-seated feeling of worthlessness which can usually be recognized as resulting from a faulty upbringing to which they were exposed from early childhood on. Parents who were at once possessively over-demanding and intimidating, or who spurned the child's early attempts at mastery and did not give proper recognition to his achievements, and who were also at least at times flagrantly neglectful of his need for care, may have done everything to undermine his confidence in his abilities. Ruthlessly competing sibling rivals, older and stronger than the individual himself, may have done their additional share in the establishment of a predisposition to react with discouragement and despair to actual or imagined obstacles and traumatic events which led to a chronic trend towards defeat or escape.

THE NEUROTIC CONFLICT

Individuals of this type will usually feel severely frustrated in their need to master life through the realization of their potentitalities in terms of constructive achievements. As a result, they will be inclined to develop a strong compensatory need to master life by means of a self-related, self-sustaining drive for power and prestige. This may be the stuff of which dictators are made: Eventually all of the individual's mental resources may be turned to the establishment of personal power, while realistic achievements may be pushed into the background, and a sadist, perhaps in the garb of a ruthless politician, is born.

In other instances, a strong conflict may develop between the individual's fear of defeat on the one hand and his self-related, self-sustaining drive for power on the other. This conflict may be unsolvable, and out of the merging of its two irreconcilable opposites a masochist, in the form of a self-effacing, but possessively clinging follower of a strong man may be born. Or, we may have a strong conflict between the individual's need for recognition that is to be derived from constructive achievement on the one hand, and his tendencies towards defeat plus his com-

pensatory drive for power, on the other. Then, a psychoneurotic individual will have been created.

Case 1

PSYCHONEUROSIS RESULTING FROM SELF-DEPRECIATION

Such was the case in one of my patients, a 34 year old married man, who came to me because of a variety of symptoms: When eating, he would often experience a feeling of choking. This would occur particularly when he and his father were taking a meal together. He was afraid of high places, because he feared to be overcome by an irresistible urge to jump. He often felt tension and pressure in his chest together with an irregular heartbeat and a fear of heart failure.

The patient was the oldest son of three. A younger brother and sister are both married. The patient was employed in a managerial position in the wholesale business of his father and so were his younger brother and his sister's husband. On questioning, the patient admitted that there was much tension in his business relations, particularly with his father, whom he described as authoritative, self-righteous and, at the same time, as lacking in flexibility to adjust his business practices to the ever-changing conditions of the economy and of the markets, thus preventing his business from prospering fully.

At the same time, the patient felt he could not assert himself against his father except by way of violent argument. A discussion would then turn away from an objective level to a subjective, emotional one. This would make it impossible for the patient to put his views across and to obtain proper recognition of his opinions. His married life he described as altogether satisfactory although he complained of a certain lack of interest of his wife in sex relations which left him with a certain feeling of frustration.

FAMILY BACKGROUND AND PSYCHONEUROTIC MECHANISMS

In his analytic treatment, it became obvious that the patient was the preferred child of his mother, who expected great things of him and spoiled him as the "apple of her eye." The patient's scholastic achievements had always been above average. This netted him recognition from his mother which was always tempered, however, by her expectations of greater things yet to come. But hardly any recognition was to be had from his father, who refused to see anything noteworthy in the fact that the patient regularly obtained good grades.

According to the patient's account, the father was a man who always showed a high opinion of himself and of his judgment and was inclined to blame someone else when events proved him wrong. On the other hand, the patient has always felt criticized by his father for whatever the *patient* might have done wrong, and the father would use any failing or error of the son to support his view that he would be unable to exist independently of his father's support.

Altogether, the father was pictured as a man of little ability to enjoy life, whose struggle for success was largely prompted by fear of disaster rather than by pleasure found in achievement. Thus, the father would easily become a victim of "scare buying" based on irrational fears of shortages and price rises, a fact that repeatedly caused his firm great losses as a result of over-extended inventories. This compulsive tendency to "stock up" seems to have also played an important part in the father's showing himself unsensitive to the children's scholastic achievements, as he probably felt that praise could easily be construed by them as a sign of acceptance of their mental inventory as adequate and could thus encourage them to relax their further efforts.

EVALUATION OF PRESENT PROBLEMS

As forementioned, the patient's feeling of choking developed usualy when he ate with his father, usually during lunch between business hours. Off and on, it would then prevent him from eating altogether. This symptom was evaluated by us as the patient's revulsion against feeling dependent on his father (against "being fed" by him), but it also seemed to represent the patient's protest against "having things shoved down his throat" by his father—his protest against his own tendency to submit passively to his father's domination.

It was necessary to point out to the patient again and again that his difficulties in presenting his views on business matters to the father in a relaxed and therefore efficient manner, were largely based on his need to protest violently against his own temptations to accept the father as an indisputable authority to whom he would wish to submit in view of his fear of his own futility and worthlessness; but that he was also afraid to be tempted to challenge the father's superiority by establishing himself superior to him, the father, in turn.

His urge to plunge himself to death from a high place loomed as a self-destructive, masochistic solution of his conflict between wanting to submit to the father on the one hand and wanting to dominate him on the other, as by killing himself he would not only commit an act of total submission to the father by removing himself completely and irrevocably from competition with him, but he would also destroy all the hopes that his father had put in him as a son and source of support, and thus tyranize the father by inflicting severest punishment on him. Later, it was shown that the same obsessional symptom served also as an expression of a conflict about aggressive, competitive jealousy towards the patient's younger brother, who, as previously

mentioned, was working as one of the partners of the family business.

On the other hand, the patient's fear of heart trouble, the tension and pain in the region of his heart seemed to express his fear to die as a result of an unstilled longing for love from those whose acceptance and recognition were of utmost importance to him: his father who had always spurned his son's achievements; his wife, who in a manner comparable to his mother's attitude, did not wholeheartedly accept him as a man which appeared to him evidenced by her reserved attitude towards sex relations. Thus, we found in the patient a conflict between an over-strong need for love and recognition that would be based on achievement on the one hand, and an alternate striving for submission and power on the other as principal mechanisms of his neurosis, the original cause of which lay in his fear of worthlessness that he had experienced in his relations with his parents.

Case 2

PSYCHONEUROSIS RESULTING FROM SELF-OVERESTIMATION

As a counterpart to this type of individual who chronically underestimates his abilities, we have the one who habitually overestimates them and thus permits himself to become involved in situations that he cannot possibly master, which again spells defeat or lack of real success for him. Such individuals, too, may react to traumatic stimuli with severe anxiety which, however, we could in this case not consider unrealistic as we did under the foregoing conditions, as here on the contrary the individual's previously maintained unrealistically high concepts of his abilities suffer a breakdown under the impact of a reality testing.

While in the case just demonstrated, the patient had experienced himself as worthless as a result of his unrealistic underestimation of his actual abilities, we will now describe a case of the other category, namely, the one of a woman patient who experienced herself as worthless in relation to a specific task for which she lacked ability in fact.

FAMILY BACKGROUND AND PSYCHONEUROTIC MECHANISMS

This patient was in her late twenties and unmarried. Influenced by her parents' ambitions, she was obsessed with a desire to become an outstanding writer. She was a fourth daughter. Evidently she had surely been expected to be a son, and being aware that she had failed her parents in this respect, she tried to make up for it, first by outstanding scholastic achievements and finally by embarking on a newspaper career. Through her parents' connections, she obtained employment in that field, but after some hopeful beginnings as a writer of a secondary column, she found herself stalled. Unable to obtain a promotion, she felt dissatisfied, showed it, and thus got into troubles with her employer. Finally, she quit in disappointment and anger.

EVALUATION OF PRESENT PROBLEMS

After this, she became anxious and depressed and came to me for treatment. As a patient, she presented a serious problem. She wished to have her failure as a writer explained as resulting from neurotic inhibitions and as such to have it "analyzed away." When it became clear that her plight was not so much caused by blockings as it was the result of a lack of talent for her chosen field, the task of convincing her of her factual limitations was not an easy one.

Several times during the course of her treatment she quit without notice, as she was angry at me for my attempting to make her consciously accept her own growing, still unconscious awareness of the unpleasant reality of her limitations. She always returned, however, and eventually the treatment enabled her to understand that her major trouble was one of a discrepancy between what had become her ego ideal and her actual abilities.

This patient, too, had developed a strong compensatory need for power and prestige. It showed itself in her case mainly in the form of attempts to cleverly manipulate her superiors by a sort of behavior that was partially ingratiating and partially threatening in a refined, subtle manner. But in the early phase of her treatment, there was little opposition yet present in her against her unrealistic mastery drive in the form of a well established, mature need for recognition which would be based on self-realization, i. e., realization of her actual potentialities. She was then functioning essentially on an infantile level and mature tendencies which could be used for the establishment of a sound emotional equilibrium had first to be developed in her.

Showing her the unrealism of her desire to become a famous writer and encouraging her to gradually face her realistic anxiety over her growing awareness of the unreality of a task that was imposed on her by her parents, rather than freely chosen by herself, was the first step towards the development of a more mature outlook on life. Along with this went an analysis of her childhood situation which served to uncover the unrealistic influences which had instilled in her those unrealistic notions of her abilities which eventually caused her to clash with the unpleasant reality that sooner or later she was bound to meet. As a result, this patient, too, finally developed under treatment a conflict between her mature needs for self-realization on the one hand and her alternating needs for submission and triumph on the other. This conflict was finally sufficiently solved to enable her to accept her limitations and to seek

an occupation that was commensurate with her abilities.

Comprehensively, it may be said that the following principles were observed in both of the described cases which we may consider fundamental in any realistically-oriented psychotherapy:

PRINCIPLES OF REORIENTATION

1. The patients' childhood backgrounds and their detrimental influences on their character development up to the present time were analyzed. During the course of such proceedings, they experienced an emotional catharsis of previous traumatic experiences and gained insight into the nature of their various conflicts, whereby the transference on the therapist served as a link between the past and the present.

2. The patient's assets and potentialities were assessed and they thus gained insight into those positive aspects of their personalities by which the negative influences of their respective backgrounds could be offset.

3. Processes of reorientation and reconditioning took place, partially through the positive aspects of the patients' relationship with their therapist, by the corrective experience which this relationship provided for them, and partially as a learning process during which the therapist taught the patients such basic principles of sound human relationships as they had not sufficiently experienced in the past.

They were taught to respect themselves as human beings capable of contributing their important share to the great organism of human society, little as this share may appear to them. And they were taught that sound relations with others based on mutual respect, cooperation, and honest forthright competition are infinitely more valuable to them than a self-seeking need for social triumph and prestige.

As a result of these endeavors, the patients' self-confidence increased. Their trends towards defeat gave way to an increasingly stronger drive towards achievement and success and their neurotically overdetermined drive for power and prestige was reduced to realistic proportions and integrated into their struggle for self-realization. Finally, the wound that had opened as a result of a pathological conflict between their mature need for self-realization on the one hand and their conflicting sadistic and masochistic needs on the other, was healed. Thus, the patients were no longer at the mercy of fate, helplessly exposed to traumatic stimuli from the environment.

Speaking generally, the following takes place in a realistic psychotherapy: Pathological reaction patterns which individuals have formed through unrealistically-oriented influences to which they were exposed, and hence resulting unrealistic notions and concepts about themselves which they have developed, are replaced by reality bound attitudes and behavior formed under the realistically-oriented influence of the therapist.

B. UNREALISTIC PSYCHOTHERAPY

If we declared at the outset that there are realistic and unrealistic methods of psychotherapy and have now tried to outline the principles of a realistically-oriented treatment, then the question arises, what an unrealistically-oriented therapy would be like and how it would operate.

Inasmuch as in psychotherapy we are dealing with influences exerted by one human being on another which are supposed to effect a change in the person thus influenced—a favorable change, that is—then we will have little doubt that an influence of this general nature could be exerted in various unrealistic ways. As a matter of fact, there have always been people who asserted that the whole procedure is fantastic, that its successes rest on make-believe, that no matter what specific methods are supplied, faith remains its one and only effective therapeutic agent.

Of course, we cannot forget that the first psychotherapists were priests and to a considerable extent they still are. The priests of prehistoric times and of the ancients, as well as of primitive man of our time, also acted and act as physicians. Faith was and is used by them as a powerful force not only in the alleviation of mental suffering but also in the cure of organic illness.

THE ROLE OF FAITH

What is faith? I would say it is an individual's belief in his alliance with a power which he experiences as a higher one inasmuch as he cannot grasp it by means of intellect and logic. We all know the power of faith, how it can enable individuals to carry on with a struggle that they would otherwise fear to face. It would mean blindness to the facts of life not to admit the important role that faith usually plays in all struggles for survival, including, in a foremost place, the struggle of the ailing organism for the restoration of his health. The power with which the faithful individual believes to be allied in his struggles is often considered to be a frankly supernatural one, but this is by no means always true.

THE BELIEF IN THE POWER OF SCIENCE

Looking again at our definition of faith, we will find that it also covers a power that anyone will consider factual and proven, namely the power of science. Science, too, is not always, or rather rarely, within the intellectual grasp of the individuals who avail themselves of its blessings. And it is true that even those who are actively at work in any one scientific field and have a great deal of knowledge of its actual and potential scope often rely on faith as an adjuvant for purposes of maintaining or strengthening their

initiative when they feel that reality alone would overtax it in the face of heavy doubts about the outcome of their endeavors. I believe, however, we are right when we say that any faith, even the faith in the power of science, has a certain supernatural quality if strictly considered by its own merits.

Thus, the patient who faithfully believes in the power of medical science which his doctor puts at his disposal, the ways and means of which are unknown and incomprehensible to him in detail, really sees more in it than the sum total of all knowledge that is available in the particular scientific area in which his illness lies and that he sees as working in his favor. In fact, his desires will carry him farther. Disregarding its limitations, he will see in this knowledge, or he will at least be inclined to see in it, an overwhelming force of a magical quality which will fight his battles for him.

To the practitioner of medicine this will represent a difficult problem. If he wishes to make available to his patient the power of faith as a valuable adjuvant in strengthening his patient's determination to get well, he will be inclined to promote the patient's faith in the magic power of his science, all the more as this will put him, the doctor, in the role of a priest and therefore above criticism and reproach.

But there is a potential drawback in such a development. If the patient puts too much faith in the magic power of the practitioner and his science, he may easily be inclined to relax his own efforts which are so necessary in the process of a cure. Even physical cure is still largely based on the strengthening of the organism's own resources of defense. The adage *"Natura sanat, medicus curat"* is still essentially as valid in the days of antibiotic, chemical, and hormonal therapy and advanced surgery as it was thousands of years ago when well wishing and prayer were the most essential paraphernalia of the men engaged in helping the sick.

It is particularly valid in psychotherapy where no change to a healthier and happier existence is possible at all without the patient's own efforts to establish more successful relations within himself and with the outside world than those previously maintained by him.

NEUROSIS AS PROTECTION FROM THREATENING REALITY

But how can he find the courage to face a world of reality from which his neurosis has heretofore separated him and which is therefore as strange to him as the Aztek culture was to the conquering Spaniards? Surely, the temptation would be great on the side of the therapist to use the patient's readiness to develop a blind faith in the power of the therapist and his science for the purpose of selling him a world with which he, the patient, would feel at once in better contact and that would, therefore, provide fewer obstacles to him than that real world which would at once confront him if he stopped to anxiously recede from it.

If you disregard for a moment his inner reality and look only at the world around him, think how complex it really is: The same people who are his relentless competitors will also be his friends when common interests are at stake. The woman he loves, he will by the same act by which he expresses his love expose to the discomfort and suffering of pregnancy and childbirth. His children whose welfare he wishes to promote as his own, will tax his patience and tolerance by their defiance. Has not his neurosis always protected him from meeting these and other real problems by keeping him occupied with the formation of symptoms which took the place of real solutions?

In fact, we would put ourselves as therapists in a precarious position of overlooking a most essential dynamic factor if we disregarded the protective value of a neurosis. One important reason why people tenaciously cling to their neurotic patterns is precisely because they do not want to lose that protection. Giving up a neurosis means renouncing a proven, though inadequate, protection for a struggle of unknown scope.

We defined psychoneurosis in terms of conflict within a personality between a mature drive for achievement on the one hand and alternating drives for domination and submission on the other. But from experience, we know that the neurotic struggle that takes place before therapy is essentially concerned with the defense of infantile neurotic patterns against the growing awareness of the individual's own realistic needs and against the pressure of the reality around him.

It is consistent with this fact that the untreated neurotic is essentially and predominantly preoccupied with the satisfaction of autoerotic needs. Persons of his environment are primarily used by him as willing or unwilling tools for the recreation of his autoerotically determined conflict patterns. Yet, the neurotic suffers from the frustrations that are inherent in a condition which keeps the inner reality of his productive and constructive self shut off from the outer reality of the constructive forces of the world. Thus, he misses his chances to develop and grow, because he is not free to assert himself against the destructive and self-destructive forces within himself and finds himself hamstrung by fears that because of his lack of knowledge and experience with constructive ways of living, he may not be able to overcome those destructive forces which operate in the outside world in opposition to his constructive needs and in favor of his neurosis.

UNREALISTIC "ANALYSIS"

We can now readily see how an unrealistically-oriented therapy would operate. There are essen-

tially two unrealistic principles on which a therapist could rest his treatment with the aim of eliminating at least a part of the patient's inner conflict between his mature constructive self on the one hand and his infantile neurotic self on the other. Taking advantage of the patient's readiness to develop blind faith in the therapist's magic-omnipotent power, he could on the one hand sell to the patient his environment, the world in which he is living, as one that is and always will be essentially run by blind elementary forces which are similar to the patient's own infantile neurotic needs: Forces of aggression involving principles of domination and submission, as well as sexual forces which operate independently of emotional needs for love. Furthermore, he can sell him his own, the patient's, infantile needs as overwhelming forces within himself with which he could at best effect a feeble compromise, but which he could never hope to control by way of integrating them into constructive ways of living.

UNREALISTIC "CURE"

Commensurate with this picture of a world inside and outside of himself that is essentially and irrevocably governed by blind forces of sex and aggression, would be a policy of encouraging a patient to act out his own sexual and aggressive impulses to the extent as he can afford safely without getting into such conflicts with the environment as would damage his immediate self-interests, no matter whether the overall effect of his actions would be constructive or not.

There is no doubt that such a course will provide a patient with a release of pent-up energy that he will experience as a great relief. This picture of a world that is irrevocably dominated by blind elementary forces which correspond to the one of overwhelmingly strong elementary and destructive forces within himself, will also lend itself to relieving the patient of another pressure, namely the one brought to bear by guilt caused by feelings of responsibility for his own misery, as it will make it appear to the patient that he is nothing but a tragic victim of predetermined processes over which he has at best only limited control.

This would mean that while the realistic consequences of his defeats would then, of course, be still with him, he can at least find refuge in the comforting thought that it is after all not **he**, not his own omissions which are the cause of his failure to achieve on the level of his abilities, but the elementary forces of so called "nature" which operate in him, in his environment and in the world at large.

The cultivation of a belief that sees Man as a helpless victim of the dark forces of nature beyond his reach and control, may even help a patient to actually eliminate external failures and to establish himself as a success by joining hands with the immature, aggressive-destructive and submissive forces of the world so as to make them serve his immediate personal advantage.

It goes without saying, however, that such policies will of course never solve a patient's basic conflict that is brought about by the frustration of his need for realization of his potentialities.

This need represents in fact a deeply rooted outgrowth of human nature, more deeply rooted than all primitive sexual and aggressive impulses, as it springs from the survival need in reaction to the individual's taking cognizance of the inescapability of his death and his hence resulting need to express himself in such dynamic ways that will enable him to survive through deeds.

IDEOLOGICAL PRINCIPLES

In conclusion, we hold the following ideological principles to be valid in a realistic psychotherapy:

Biological and psychological theories which in disregard of modern scientific progress still see the world as more or less static, and nature, specifically human nature, as subject to unalterable laws, should be abandoned. There is no law or decree in nature that what has seemingly always been, must therefore always be, because it once was.

Once they told us that we could not fly because anything that is heavier than air must fall. They told us that we could never change the elements. Nature, however, is subject to change. Everything flows. If we do not change, then it is because we **choose** to stay as we are.

Our reality will be what we make it. If we choose constructive achievement as our reality and work for it, then we can have a satisfying reality inside and outside ourselves that will eventually give us the peace of mind for which we are longing. If we choose destructive and self-destructive ways of living as our reality and work for them, then we will have at best limited satisfaction in a reality that is essentially insecure and frustrating to us. The only thing that can thwart our active will to change is the absence of the means by which a change can be brought about. If we feel that we lack the means by which to effect a desirable change that will permit us to meet reality—**our** reality—in the best satisfactory manner, then we should make efforts to find these means.

But no matter what the outcome of this struggle may be, it remains of overall importance to realize that there is no law in nature that precludes change. Therefore, there is no reality that we have to fear as an unalterable set of conditions. The only reality that Man should recognize as unalterable, is his unlimited will to live.

Observations Concerning the Pathogenesis Of Bronchiectasis

OSCAR NEUFELD, M. D.

BRONCHIECTASIS is a progressive disease and subject to early diagnosis by advanced method of bronchoscopy and bronchography. In a reasonable number of cases of bronchiectasis the disease is curable by radical means and the success of this effort is dependent upon early recognition. It is now universally recognized that chronic productive cough is a symptom which demands explanation in every instance. It cannot be properly ascribed to "chronic bronchitis" or "sinusitis" until the actual anatomy of the tracheobronchial tree has been studied by means of bronchoscopy and bronchography.

Bronchiectasis is not a rarity, and early office diagnosis is not usually made. The original symptoms (even though many are symptomless) are persistent coughing of varying severity with or without expectoration and no characteristic bacteriologic picture. Hemoptysis and wheezing are rather common but sinusitis is only an occasional occurrence. A recurrent febrile exacerbation of short duration is a frequent clinical feature. Another occasional occurrence is clubbing of the fingers.[1]

It is therefore very important that every patient who has had an acute respiratory infection or evidence of obstruction, chronic cough or atelectasis should be followed roentgenographically regardless of the fact that symptoms may have ceased entirely. Physical examination is insufficient for recognition of bronchiectasis and so is the ordinary posterior-anterior chest film. Atelectasis, triangular shadows or fibrosis, massive collapse and increased bronchial markings are striking x-ray features. The diagnosis, however, can be confirmed only by bronchographic examination. No doubt, we could prevent many instances of acquired bronchiectasis if we were to depend more upon the roentgenogram and bronchogram.

The true aim of treating bronchiectatic disease is preventing of the crippling deformity of the bronchi and lung tissue. Respiratory infection, obstruction, cough and atelectasis lay the foundation for the development of bronchiectasis.

DILATED BRONCHI RETURN TO NORMAL WIDTH

As generally understood bronchiectasis is an acquired or congenital dilatation of the bronchi. This is true, except, that the dilatation or enlargement of one or more of the bronchi is only the demonstrable effect of a pathological process which damages the tissue of the lung and bronchi sufficiently to interfere with their function. By no means is the dilatation, per se, the most important factor. Bronchial dilatation does not necessarily mean that the bronchi are diseased.

Normal bronchi will dilate when subjected to extensive strain and will remain dilated until the strain is removed. This is a frequent occurrence in atelectasis, artificial or spontaneous pulmonary collapse and can be demonstrated by means of bronchoscopy and bronchography.[2,3,5,7,8] With the restoration of aeration and drainage the defensive power of the lung is re-established and the dilated bronchi return to normal width. Such is the case in early stages of ectasia with no severe destruction of the bronchial walls or pulmonary parenchyma.

Artificial collapse of the lung such as pneumothorax causes temporary ectasia but re-expansion of the lung causes disappearance of the bronchial changes. Pulmonary atelectasis is occasionally caused by artificial pneumothorax particularly in the presence of bronchial infection, and can be considered safe, as far as bronchial dilatation is concerned, as long as no negative pressure develops. Bronchograms following lipiodol® injections regularly show dilatation of the bronchi throughout the atelectatic area. Reareation of the atelectatic area by means of bronchoscopic drainage or other treatment reverses early bronchiectasis and returns the bronchi to normal width. These have been observed by a great number of investigators including Ochsner,[5] Lauder and Davidsohn,[2] Wilson,[7] Fleischner,[8] Ogilvie[3] and many others. In other words, with the restoration of aeration and spontaneous drainage the bronchi return to pre-existing condition, as far as dilatation is concerned.

A great number of removed lobes for bronchiectasis in early stages[2,3,4] show that the supporting mural structures of the dilated bronchi were grossly intact or almost so, and in few instances not even signs of active or chronic inflammation of the bronchial mucosa could be found. We quote Mallory:[4] "In a survey of lobectomy specimens I found severe bronchial inflammation of the type described by Robinson (see *Brit. J. Surg.*,

Submitted November 16, 1953.

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● Dr. Neufeld, Toledo, Ohio, is a member of the American Trudeau Society, National Tuberculosis Association; on staff Mercy Hospital, Flower Hospital.

21:302, 312, 1933, and *Am. J. Path.*, 15:638-640, 1939) in 35 of 50 cases. In the remainder the inflammation was comparatively mild and in a case of so called 'dry bronchiectasis' was entirely absent. There was no close parallelism between the severity of inflammation and the degree of bronchial dilatation. Moreover, in a series of lungs from patients who had suffered from chronic asthma, in which no dilatation of bronchi was present and in which inflammatory infiltration sometimes exceeded that found in frank bronchiectasis, active necrotizing bronchitis was observed in only three cases."

With the development of thoracic surgery it is rather common that micro-sections in early bronchiectasis show very infrequently evidence of bronchial destruction. The medium and small caliber bronchi, regardless of the degree of dilatation show a preservation of elastic fibers and the smooth muscles. Stretching out of the wall or the degree of dilatation causes some diminution in muscular and elastic structures, which is to be expected.

IRREVERSIBLE BRONCHIECTASIS

In irreversible bronchiectasis destruction of tissue and not dilatation is the fundamental essence of the problem. The disease is rarely seen as an isolated finding in otherwise normal lung. Studies of the pathogenesis of bronchiectasis lead to the conclusion that bronchiectasis cannot be regarded as purely true bronchial dilatation; it comprises usually abnormal surrounding lung with atelectasis, fibrosis, focal emphysema and other forms of destruction of pulmonary parenchyma.

Space does not permit to discuss all the mechanical dilating forces acting upon the bronchial wall in the production of ectasia which have been considered. Briefly, a number of investigators have considered as dilating forces: pressure of secretion, excess pressure of intrabronchial air over the gas pressure in the surrounding parenchyma, traction from the non-ventilated lung tissue, retraction due to atelectasis and pulmonary fibrosis, congenital anomalies, nutritional changes in the bronchial wall suggesting a malnutrition of the cilia, impairment of resistance of the tissue to infection, paralysis of the circular muscle fibers of the bronchi with loss of ciliary action, atrophy of the musculature, impaired bronchial cleansing, etc.

Of course, pressure from inside or pressure of retained secretion would pertain only to the most commonly affected portions of the lung, to the lower and middle lobes and to some dependent branches of the upper lobes. In a partially obstructed bronchus the retained secretions therein would exert in erect position a hydrostatic pressure equal to 10 cc. of water. No doubt, that normal bronchial wall, when supported by aerated lung tissue, withstands this pressure. A frequent cause of raised intrabronchial pressure is collapse of the lung, which has been proven to act in this way. Airlessness of the neighboring parenchyma removes the strong "cushioned" support given normally to the bronchi by aerated lung tissue, thus producing a real intrabronchial pressure greatly above normal.

Pressure of secretion in a completely closed bronchus is by far a stronger dilating factor but this is an unusual occurence except for aspiration of foreign bodies and in patients with bronchiectasis no such proximal bronchial obstruction can be demonstrated to have preceded the development of bronchiectasis.[11] In rare instances of rapidly developing complete bronchial obstruction, the secretion accumulating in the closed bronchi may contribute to bronchial dilatation by pressure from within. (Fleischner.)

In reviewing the foregoing theories we believe that several factors produce a progressive and vicious circle of events in the development of bronchiectasis. This represents something of a chain-like process involving bronchial infection, obstruction, impairment of bronchial cleansing or drainage, atelectasis, fibrosis or other forms of pulmonary damage.

INFECTION

The importance of infection in bronchiectasis is beyond dispute although it represents a contributing, but not primary, factor in its development. The available evidence as to the actual conditions of the bronchial wall in true bronchiectasis on the study of "living" lobes and postmortem material reveals chronic inflammatory conditions of the bronchial walls with various degrees of damage, up to complete destruction of the musculo-elastic tissue. The invasion of the bronchial walls by pathogenic bacteria is followed by varying degree of destruction, with loss of elastic elements in the bronchial walls. The secretion is increased and the cleansing action of the dynamic bronchial tree impaired. This permits the establishment of a chronic infection which may destroy irreplaceable structures in the wall of the bronchi.

OBSTRUCTION

To visualize the importance of the cleansing mechanism of the lung and bronchi one must realize that the coughing act is a dynamic act of the mucous membrane which expels the secretion or air by means of a high speed peristaltic wave originating in the small bronchi and ending in the vocal cords. Peristaltic waves have been observed in the bronchi and are considered by some to play an important role in the evacuation of secretion.

Cough—the defense of the bronchopulmonary system—so helpful in the expulsion of bronchial contents, is less effectual in bronchiectasis. Lack of aerated alveoli behind the involved bronchi renders cough ineffective as a mechanism for

clearing bronchial secretion; bronchial branches destroyed by infection lose their dynamic properties and any possibility of bronchial peristalsis taking place in rigid and destroyed bronchi is hopeless. In addition, the cleansing mechanism of coughing is frequently decreased by high position or limited excursion of the diaphragm, pleuritic pain, chronic lung infection, etc., leading more easily to retention of secretion in the dependent posterior and basal portions of the lung. The significance of the coughing act and cleansing mechanism become evident if one compares the ease or difficulty in getting rid of bronchial secretions for various individual localities in the lung with the frequency of bronchiectasis occurring there. The dependent position of the lower lobes favors the retention of bronchial secretion, atelectasis and consequently bronchial dilatation.

Upper lobe bronchiectasis is usualy relatively benign because the drainage is downhill and the excellent drainage of the upper lobe afforded by gravity might explain the failure of secretion to accumulate, to become infected and to produce the characteristic symptoms of bronchiectasis. The left lower lobe is the one most frequently involved in bronchiectasis and when bronchiectasis develops here, the lingular segment of the left upper lobe frequently becomes affected. Churchil and Belsley found the lingular segment sufficiently involved to require surgical removal in 80 per cent of the cases requiring removal of the left lower lobe. This frequent left sided localization is probably a matter of drainage; the left main bronchus and its branches make more of an angle with the trachea than does the right one, which is more of a continuation of the trachea.

ATELECTASIS

Pulmonary parenchyma, besides many other vital functions, protects the bronchi against the respiratory tugging of the chest and all intrapulmonary bronchi are completely surrounded by air cells. The reduction in aerated parenchyma such as occurs in atelectasis lowers the intrathoracic pressure. Intra-pleural pressure values of -70 to -74 mm. of mercury have been found as compared with the normal of -4 to -6 mm. In addition, an effective air cushion consisting of hundreds of millions of inflated alveoli supports and strengthens the bronchial system. In atelectasis this support is lost to the bronchi. This loss renders these bronchial walls more liable to dilatation.

In atelectasis the air within the alveolar sacs disappears mainly by absorption into the capillary blood and due to the collapse of the empty alveoli and smaller bronchi, the affected portion of the lung contracts in volume. In case of segmental involvement the adjacent parenchyma will reexpand; when the involvement is large, comprising a lobe or whole lung, the mediastinum, diaphragm and intercostal spaces will be pulled in by the contracting lung causing impairment of normal ventilatory expansion. Similar mechanical disturbances will be caused by emphysema or fibrosis.

Andrus[10] believes that in atelectasis the difference in pressure inside and outside the bronchi is a dilatory force, the expanding thorax transmitting a "pull" upon the bronchi through the solid, atelectatic tissue. There is no doubt at all, that the very low intrathoracic negative pressure generates an effective dilating force on the bronchial walls. This condition certainly is irreversible in cases of pulmonary fibrosis but potentially reversible in early atelectasis with no severe bronchial and pulmonary damage.

CONGENITAL BRONCHIAL ANOMALY

It might be worth while to mention briefly congenital bronchiectatic lesions mainly due to developmental anomalies either by obstruction from associated structural lesions or by abnormal growth of the bronchi themselves. Olsen reviewed the syndrome known as Kartagener's triad, which consists of an association of situs inversus, bronchiectasis and sinusitis, and reports 85 cases of dextrocardia seen at the Mayo Clinic from 1920 to 1941; evidence of bronchiectasis was found in 16.5 per cent of these cases in contrast to less than 1 per cent of bronchiectasis in all other patients registered there.

Dickey reports five cases of dextrocardia; four had complete situs inversus, one dextrocardia only. All of the children had pulmonary atelectasis and bronchiectasis. He believes, that the sequence of events in the development of Kartagener's syndrome is dextrocardia, atelectasis, bronchiectasis and sinusitis. The congenital bronchial anomaly known as congenital cystic disease of the lung originates probably from a failure of canalization of the smaller or terminal bronchioles, with arrested development of the corresponding area of lung, which becomes cystic. They contain fluid identical with the contents of the fetal bronchial system which may be expelled and remain as air cyst.

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Education for General Practice

NATHAN J. KURSBAN, M.D.

RECENT surveys show that increasing numbers of medical students are planning a career in general practice. Within the span of a decade, this number has increased from 10 to 60 per cent. This increase has been stimulated by a growing demand from the public for physicians who will render a general family service.

In recognition of this demand, organized medicine has given increased attention to the role of the "family physician." Dr. Malcolm T. MacEachern, past-director of the American College of Surgeons, referred to the family physician as the "key figure in medical service to the patient."[1] Dr. Edward J. McCormick, President of the American Medical Association, in his inaugural address urged every family "to select for itself a family physician in whom it has confidence and whose advice will be followed in emergencies and when seeking the services of specialists."

In view of such emphasis, it becomes necessary to insure the continued production of qualified general practitioners, and medical schools and hospitals must provide the training facilities toward this end. While training programs have been established for students in medical and surgical specialties, relatively few programs have been developed for them in the field of general practice.

MEDICAL CURRICULUM

Yet, an effective training program towards general practice should begin in the undergraduate years. Medical educators recognize the need to revise the medical school curriculum so as to enable the student to "acquire a better understanding of the total patient in keeping with the mounting conviction that psychological and environmental factors are of consequence in health and disease."[2] Such curriculae should be influenced by the experience of practicing general physicians, and should include nonclinical as well as clinical subjects. Dr. Ward Darley, president of the Association of American Medical Colleges, expressed this viewpoint when he stated that "more attention should be given to the significance of the interplay that is developing between medicine and our socio-economic structure."[3]

In his presidential address, Dr. George P. Berry, immediate past-president of the Association of American Medical Colleges, questioned "the mounting tendency to impose specialization on the teaching of the medical student."[2] He further states, "Our preoccupation with scientific medicine has tended to let the patient fade into a faceless, nebulous creature, often no more than a number on a test tube or an entry on a chart. Such an attitude is not consistent with the best medicine. Moreover it is not scientific. While the student is learning a great deal about the patient's 17-ketosteroids, undeniably important, he tends to overlook the patient's anxieties and hatreds, his attitudes in his family setting and the pressures that hem him in. These too, are important. They must receive greater attention. Scientific medicine is a misnomer, I think, when it is exclusively preoccupied with the physical or chemical constitution."[3]

The Commonwealth Fund, which has sponsored experimental programs in the field of medical education, has adopted a similar outlook. The Fund's Annual Report published in 1950 stated, "If teaching is built around the needs of a student who is learning as he grows, and is not cut to a pattern determined by the competitive demands of medical school departments, it will gain coherence and pith. If the medicine that is taught is fitted to the needs of the patient on whom it is practiced, it will recognize and deal with far more than it does today, all the forces that shape his life, forces from within and forces from his environment continuously interacting and continuously affecting the balance between his sickness and his health."[4]

GENERAL PHYSICIAN PARTICIPATION

The family physician, dealing as he does with the patient as a whole in his total environment, uniquely qualifies himself to participate in such a teaching program. He has a great appreciation of the home and community life of the patient as factors in his illness and health. Students, interns, and residents must similarly be taught to recognize these factors in the illness situation, and to manage it accordingly.

Qualified general physicians should participate in training programs of private and university affiliated hospitals under the supervision of

Submitted December 7, 1953.

The Author

● Dr. Kursban, Cincinnati, charter member of the American Academy of General Practice, is chairman, General Practitioner Section, Jewish Hospital, Cincinnati, and president, Southwestern Ohio Society of General Physicians.

general practice departments. They should have faculty or staff status comparable to that held by members of specialist departments. The general practice department should not be a clinical service for the admission of patients, but should rather primarily be an administrative division of the staff. Organization of general practice departments in hospitals will, in addition, give the practice of general medicine proportionate "standing" with the specialist services. General physicians will have added incentive to qualify for membership in such departments and will more readily accept responsibility in teaching programs requiring time and effort.

GENERAL PRACTICE TRAINING

The first phase of a general practice teaching program will concern the undergraduate student and should include the following:

1. Lectures by members of the general practice department in the art of medical practice, medical economics, ethics, public relations, and the care of patients in private general practice.
2. Clinical instruction by members of the general practice department in the outpatient dispensary of the hospital. The student will be instructed in examination, diagnosis, and treatment.
3. Clinical instruction by members of the general practice department on selected ward cases and on private patients of general physicians with their consent.
4. Preceptoral programs under which the student will be assigned to a member of the general practice department and be afforded an opportunity to observe the activities of a general physician both in his home and in his office.

Such a program offers other advantages. The student will acquire better orientation and knowledge to guide him in the choice of a career in medicine. An understanding of the problems of general practice by students will make for improved relationships between future general physicians and specialists. The student will have a clearer conception of the limitations of highly institutionalized education; and finally, he will be better grounded for intern and resident training, even though this training may be for a specialized field of practice.

A second phase of the program is training at the intern and resident level. Present internship service of one year does not provide the general physician in training with sufficient experience. The American Academy of General Practice has advocated a minimum of two, and preferably three years of hospital training. Duration of training, and the practice in which prospective general physicians should be trained, and the amount and kind of surgical training they should receive are problems of a controversial nature which will achieve constructive solution only as we acquire more experience with such programs. The trainee in general practice should not be inordinately used by specialist departments for routine chores, as has so often been the custom in the past.

POSTGRADUATE TRAINING

Education in general practice must provide means by which the practicing general physician can continue his education. A policy of continuing postgraduate training for general physicians has been adopted by the American Academy of General Practice, and in fact, has become a requisite for continued membership. The Academy has promoted postgraduate training courses through its state and local affiliates. It has received excellent cooperation from state medical societies and from medical schools which have made their staffs and facilities available for courses, symposia and seminars.

SUMMARY AND CONCLUSIONS

The general physician is a majority member of his profession and his value to the community is great. His competence will determine to a great degree the esteem with which the medical profession as a whole is held by the public. We must therefore provide sufficient numbers of competent general physicians through carefully supervised training programs. Such programs should begin at the undergraduate level and extend through the internship, resident, and the postgraduate years. Toward such a goal all must work. Only through the expenditure of joint effort on the part of general practitioners, universities, hospitals, and specialists will the family practitioner ultimately achieve his proper place in medicine, and perform his greatest service for the community.

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Occupational Aspects of Coccidioidomycosis

Seven of fourteen Standford University faculty members and students who were exposed to dense concentrations of dust in the air while on a field trip to San Benito County contracted coccidioidomycosis.

The incubation periods were between nine and fourteen days.

The fungus was later recovered from the soil at the site. Were the field trip incident to their teaching duties, it would seem a fair assumption that, for the faculty members, the coccidioidomycosis so incurred was occupational.—Norman E. Levan, M.D., Bakersfield: *California Medicine*, 80:294, April, 1954.

Torsion of Uterine Adnexa: Report of a Case In a Girl Three Years Old

T. N. MANOS, M.D.

TORSION of diseased adnexa is an accepted fact. Ovarian tumors, especially cysts, as well as hydrosalpinx and hematosalpinx are very prone to undergo torsion.[1]

Such a condition is well known to gynecologists and to medical men in general. It is also known that apparently normal adnexa can undergo torsion, but there is another phase of the subject as a whole, with which the medical experience has been relatively little and that is the torsion of uterine adnexa in children.

In considering the matter of torsion of so small an appendage one must reckon with the length of the mesosalpinx and the relative size of the ovary or the length of the tube.

Auvray, of France, quoted by Smith and Butler[3] believes that a spiral course of the tube which is normally present in fetal life and may persist as a congenital anomaly in the child to a marked degree may be a predisposing factor. All this, of course, is merely speculation and is difficult to prove if not impossible.

Torsion is said to occur more frequently on the right side than on the left at a ratio of 3 to 2.

Smith and Butler[3] also advance Anspach's theory of greater roominess of the pelvis on the right side by virtue of the sigmoid being on the left side, and the fact that peristaltic action of the cecum and small intestine is greater than that of the sigmoid.

CASE REPORT

The patient, a three year old girl, rather small in stature, weighing only 29 pounds, had been in good health up to 18 hours prior to admission. At that time she complained of pain in her right side, no nausea or vomiting until some 12 hours later, when she vomited two or three times. She was admitted to the hospital with a diagnosis of acute abdominal crisis.

She appeared acutely ill with normal temperature, complaining of pain in the lower right abdomen. No further physical examination was possible because the little girl would not cooperate. Urinalysis was negative. Blood count showed hemoglobin 12.4 grams; erythrocytes 4,740,000; total white blood count 12,450 with 82 per cent neutrophils; 3 per cent eosinophils and 14 per cent lymphocytes. From the history as given by the child's mother and the blood count, she was taken to surgery with a diagnosis of appendicitis.

Operation: The abdomen was opened by a right transrectus incision. The cecum was located and delivered, the appendix was found to be normal. The finger was reintroduced into the abdomen, to palpate the right adnexa, before we ran the ileum for diverticula, and a rather large mass was palpated. This mass was then brought through the incision and a right salpingo-oophorectomy performed. On inspection the surface of the greatly thickened tube was deep purple, the ovary was roughly ovoid in shape, and the color a reddish purple.

Diagnosis: Due to the fact that the adnexa were not in torsion position we thought of a thrombotic process and we ran a few more tests: Prothrombin 13 sec.; Platelets 270,000; Cholesterol 410 mgm.; blood calcium 10.8 mgms.; and 5.4 per liter. All of these being within normal limits, we finally made a diagnosis of torsion of the adnexa, which diagnosis was confirmed by the pathologists when they failed to find any evidence of thrombosis to account for the hemorrhagic infarction of the tube and ovary.

The patient made an uneventful recovery and left the hospital on the third postoperative day.

Submitted December 9, 1953.

The Author

● Dr. Manos, Columbus, is senior surgeon on staff of White Cross Hospital.

COMMENTS

The diagnosis is difficult, chiefly because of the rarity of this condition and the similarity of the symptoms to those of other acute abdominal crises.[2] The mistaken diagnosis is usually that of appendicitis in more than 50 per cent of the cases. The presence of a well defined tumor is probably the most distinguishing differential point and it was absent in our case.

One thing should be certain in our minds: That we deal with an acute abdomen and that postponement of surgical intervention may lead to serious complications, such as rupture with hemorrhage, necrosis and gangrene, even peritonitis. It is very easy to procrastinate since the symptoms are those of an atypical appendicitis as it was in our case.

SUMMARY

1. Torsion of adnexa in childhood is rare.

2. Symptoms are those of acute abdomen. Appendicitis is often the preoperative diagnosis.

3. Another case is presented and added to the number already in literature.

4. According to our brief review of the literature this is the third case of its kind reported below the age of five years. The first one being that of: Swainson of London reported in 1910, age 2; and the second that of Sutcliffe, also of London, reported in 1907, age 3.

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The Compression Technique of Intravenous Pyelography

HUGH A. CREGG, M.D.

EVER since the development of the intravenous pyelogram efforts have been made to obstruct the ureters and obtain better retention of the dye within the pelvis and the calyces of the kidney. The latest and probably the best method appears to be that accomplished by the use of the blood pressure bag described by Zatzkin.[5]

In our experience over the past year and nine months, in which 450 pyelograms have been made, it has been possible to report as to the morphological structure of the kidney without the use of retrograde studies in all but a few cases. This has been accomplished regardless of the concentration of dye used and without special preparation of the patient. It is our conclusion now that the main factor in the production of good films is the adequate placement of the blood pressure cuff.

TECHNIQUE

The blood pressure bag is removed from the canvas covering of the blood pressure cuff and it is placed upon the abdomen. The compression band is then placed over the rubber bag and tightened. The blood pressure bag is positioned beneath the compression band so that the upper edge of the bag is an inch or more above the iliac crest. The midline of the bag must coincide with the mid-pelvis. Inflate the bag to a pressure of 80 mm. of mercury.

A preliminary film is taken and the position of the bag checked for this relationship. Positional changes are made if necessary and the dye injected. Films are taken at five and ten minute intervals with the pressure of 80 mm. of mercury. At fifteen minutes the exposure is taken immediately after release of the pressure. An upright film is taken following this exposure.

COMMENTS

Failures are due to: (1) Leakage of air from the rubber bag and pressure dropping below 80 mm. (2) Bag positioned too much to one side or below the necessary level. (3) Hypersthenic patients wiggling out of position, relative to the blood pressure bag. (4) Extravasation of the dye at the site of injection. (5) Renal insufficiency. (6) Patient's inability to tolerate the pelvic pressure.

It has been possible with this technique to eliminate otherwise unnecessary retrograde visualization; to simplify cystoscopy by avoiding the necessity for retrograde examination; and to visualize the kidneys in a patient who is unprepared for the examination. It is found to be of real value in children and infants whose kidneys often cannot be studied by other than retrograde visualization. In obtaining films of children 40 mm. pressure is used and found to be satisfactory. The pelves and calyces are usually well visualized in spite of marked gaseous distention.

It has been our practice to require no preparation for intravenous pyelograms. The patients have been allowed to eat and using 50 per cent neo-iopax® we have not had any difficulty with vomiting. The few cases of vomiting seen were brought on by the patient's reaction to the compression effect of the blood pressure bag. Release of the pressure will be necessary to relieve this discomfort in very few.

Submitted June 8, 1953.

The Author

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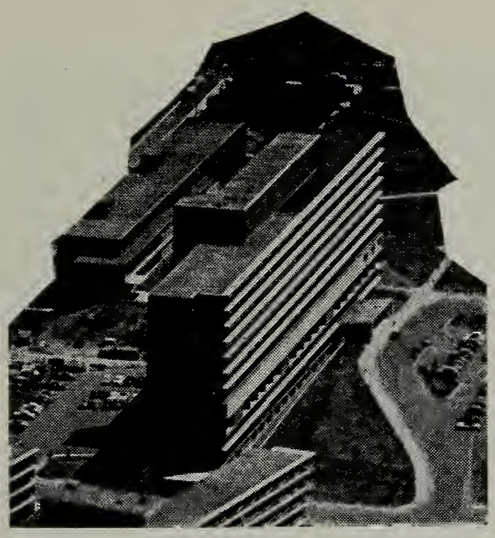
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ACTH and Cortisone in the Hypersensitive State

It is in asthma that these hormones have made a great contribution. The difficult so-called "status asthmaticus" case is seldom encountered and the many days of hospitalization required in clearing these cases is now eliminated. During the past year it has not been necessary in our practice to have a single emergency bronchoscopy done on an asthmatic. In this condition ACTH is the drug of choice for hospitalized cases.

In using it we feel that we are stimulating production of all fractions of the steroids of the adrenals. In this type of case response is good and administration can be inexpensive by giving 15 mg. in 1000 cc. of 5 per cent dextrose in water intravenously, slowly over a minimum of 8 hours. —James E. Stroh, M.D., and James W. Georges, M.D., Seattle: *Northwest Medicine*, 53:372, April, 1954.



A Case Record

From The University Hospital
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Burr M. Hathaway, M.D., President

Presented by: H. E. LeFever, M.D., and E. von Haam, M.D. Edited by: E. von Haam

PRESENTATION OF CASE

THIS 54 year old white female had been perfectly well until three weeks prior to admission, when she twisted her ankle on the porch steps and fell backward, striking her head on the ground. She was not rendered unconscious and complained only of soreness and pain in the occipital region of her head; otherwise she seemed entirely normal. During the next ten days her headaches became more frequent and severe but were not related to the time of the day.

Ten days prior to admission to University Hospital she entered a hospital in Springfield, Ohio, where x-ray pictures were taken and reported as normal. While in that hospital she became lethargic, confused and began to vomit. This condition persisted to the time of admission to University Hospital. She had been in a state of inertia and incontinence for one week prior to admission.

The patient's past history revealed transient hypertension several years ago.

Physical Examination: On admission her blood pressure was 190/140, her temperature 100 F. rectally, her pulse 98. She was a well-developed, well-nourished white female who responded to verbal stimuli but seemed confused and lethargic. Cheyne-Stokes type of respiration was observed on occasion. The general physical examination was not remarkable except for obesity.

The neurological examination revealed disorientation as to time and place; speech was of a monotonous character and extremely slow; an ideational apraxia seemed to be present. She would begin to carry out a request and in a few seconds she would appear to have forgotten the idea completely. She made no effort to move about spontaneously. The right pupil was slightly larger than the left; both reacted sluggishly to light. There was slight left central facial paresis. Otherwise no significant changes were found.

Laboratory Data: On admission the red blood cell count was 3.94 millions, the hemoglobin 11.1 Gm.; the white blood cells numbered 8500 with 81 per cent neutrophils and 19 per cent lymphocytes. Two days later the red blood cell count was 4.21 mil., the hemoglobin 11.3 Gm., the white blood count 17,200 with 95 per cent neutrophils and 5 per cent lymphocytes. The urinalysis revealed a specific gravity of 1.025, albumin 10 mg., many mucus threads, 3 to 5 white blood cells and an occasional red blood cell per high power field.

Chemical analysis of the blood revealed a sodium level of 158 meq., a potassium of 4.5 meq., and chlorides of 117 meq.; the urea nitrogen was 22 mg. The pressure of the spinal fluid was normal; the fluid contained 372 red blood cells, no white blood cells, and a total protein content of 52 mg. X-ray pictures of the skull were entirely normal. The pineal gland was not calcified. An electrocardiogram was normal.

Hospital Course: The patient was observed overnight and by morning was found in a deep coma. Her right pupil was definitely dilated and fixed and her left pupil was also fixed. No focal signs were present. She responded quite well to pain and moved all extremities equally well. There were no pathologic reflexes.

A transtemporal exploration was performed, which revealed encapsulated xanthrochromic fluid over the left cerebral convexity. Approximately 130 cc. was removed by lavage and a Penrose drain was left in place. Postoperatively her pupils never changed and she remained in a coma although she moved all extremities equally well to painful stimuli. On the second postoperative day a tracheotomy was performed to facilitate removal of bronchial secretions. Her temperature at that time was 103.6 F. rectally, her pulse 100.

On the third postoperative day her condition became critical. Her systolic blood pressure dropped to 94, her pulse rose to between 160 and 170, her temperature remained at 103 F. She was started on tube feeding. Later that day

her blood pressure dropped to around 60. The intravenous administration of neo-synephrine® seemed to stabilize her pressure. During the next few days she regurgitated the tube feeding several times.

On the seventh postoperative day she seemed quite improved; she could open her right eye, the left having developed a ptosis of the lid. The pupils were small and equal and reacted very sluggishly to light. She moved her extremities spontaneously and seemed to be conscious of people moving about her. On the evening of the same day her blood pressure suddenly fell to zero, she became cold and clammy, her temperature rose to 107 F. rectally, and she went into deep coma with moist rales audible throughout the chest. An electrocardiogram was inconclusive as to the occurrence of a coronary thrombosis. She vomited her tube feeding and the bronchi were aspirated thoroughly and the tube removed.

Ten days after admission her respirations and cardiac function ceased abruptly during suctioning of the tracheotomy wound.

CLINICAL DISCUSSION

DR. H. E. LEFEVER: We are dealing with a 53 year old woman who was perfectly normal and who fell as a result of having her ankle turn and being tripped by this means. Whenever we hear that individuals have fallen down a flight of stairs we presume that they tripped when actually they may have suffered some cerebral vascular lesion which accounts for their fall. In this instance, however, we have a very excellent reason for her fall, and it is further to be noted that she fell striking the occiput upon the ground.

If a traumatic force is applied to the forehead or to the occiput, it is very much more likely to produce a lesion such as she developed than if the force is applied to the lateral surface of the head. This can be explained by the falx of the brain, which is interposed between the hemispheres and quite effectively prevents any lateral motion of the brain. In contrast to this the brain can move considerably in the anteroposterior direction and in so doing cause a laceration of the veins which cross from the movable surface of the brain to the fixed sagittal sinus. The bleeding which results will produce a subdural hematoma.

CONDITION PROGRESSES

For a period of time after this fall nothing in particular ensued. We know that the trauma which she received was not sufficient to render her unconscious, but as time passed she began to show evidences of mental difficulty. She became slow in her thinking, disoriented, and an ideation type of apraxia developed which may have been part of a complete inattention. I prefer to ascribe her incontinence to this mental state rather than to any primary difficulty with the urinary apparatus.

She led a progressively downhill course and when she was admitted to this hospital a diagnosis of a subdural hematoma was made. I think it is well that we all think of this condition because it is one for which we can do very much surgically. We note further that she had a gradually progressing disorientation leading into stupor and ultimately into coma. In addition she developed vomiting and headaches, which again must be considered as additional evidence of an increase in intracranial pressure.

It was also noted that her right pupil was dilated and that there was a weakness of the left side of the face which was of supranuclear character. Of course these signs fit together very beautifully. As you recall, the third nerve is stretched from the posterior clinoid process to the sphenoidal fissure, and if you exert pressure upon the superimposed brain the nerve will be overstretched, resulting in dilatation of the pupil and other homolateral neurological symptoms such as ptosis or extraocular palsy. From the evidence of left facial weakness we may assume that a mass lesion pressed upon the facial center of the cortex causing a contralateral facial weakness and by pressing further upon the third nerve a homolateral dilatation of the pupil. It would therefore have been my impression that the lesion occupied the right side. When the skull was opened, however, it was noted that the hemorrhage was on the left side.

FALSE SIGNS

False localizing neurological signs are so frequently present that it is now common practice to open both sides of the skull. The explanation for false localizing signs is as follows: If a lesion presses quite diffusely over the cortex of one hemisphere it may actually produce very little or no dysfunction so far as the motor strip of the homolateral side is concerned. However, it may serve to dislodge the brain stem so that it may be stretched against the sharp margin of the incisura, resulting in a dysfunction of the homolateral side after the decussation.

Those who were in attendance deserve credit for recognizing the lesion promptly and deciding upon immediate surgery. A left-sided subdural hematoma was found and promptly dealt with surgically. The whole amount of blood was evacuated and we would anticipate that the patient should have recovered quite satisfactorily. But her postoperative period was characterized by a very stormy course.

I think that there are several factors we could think of to explain why the postoperative course was so stormy. Number one is the fact that the pressure present over the cortex can dislodge the temporal lobe mesially and the uncus, the most mesial portion of the temporal lobe, may herniate through the incisura into the posterior fossa. This is known among neurologists as an uncal herniation. Frequently when the cortical pressure is removed, the uncus will return to its normal

position in the middle fossa and leave no evidences of its having been displaced. On the other hand, the uncus may become impinged in this state and incapable of returning to its normal area, and if this is the case it will swell and exert pressure upon the brain stem. After this persists for a period of time, two or three factors may develop which seriously jeopardize the individual's ability to recover.

THROMBOSIS

The posterior cerebral artery may be compressed leading to a thrombosis in the trajectorate of this great vessel and causing serious disturbances in the patient's vision. This same pressure exerted by the herniated uncus upon the brain stem can also produce a venous stasis and lead first to petechial and later to conglomerate hemorrhages in the brain stem. Whenever we suspect the presence of an uncal hernia in a patient who is not doing satisfactorily after the clot has been removed, we feel that it is often a life-saving measure to section the tentorium and thereby release the pressure that is exerted upon the brain stem. However, it is too late to section it after the conglomerate hemorrhage has occurred and we must section the tentorium early whenever we anticipate an uncal hernia.

THIRD NERVE PALSY

You note that after the operation the patient developed a ptosis of the left lid while none had existed previous to surgery. As you know, the third nerve occupies a high position in the brain stem and it is a location where any pressure such as exerted by an uncal hernia or a hemorrhage would easily lead to a dysfunction of both nerves. Therefore a bilateral third nerve palsy is almost invariably indicative of a brain stem lesion.

There is also the possibility that this individual may have developed some difficulty with her food intake. There was some regurgitation, the character of which is not described. Then there was a sudden serious accident that apparently produced severe shock. We do know that pressure on certain areas of the brain may produce a neurogenic ulcer of the stomach or small intestine and that there may even have occurred a necrosis of the esophagus leading to peritonitis and death. In conclusion I wish to state that this patient probably suffered from some degree of uncal herniation and that this in turn was responsible for her death.

CLINICAL DIAGNOSIS

1. Status post-evacuation of subdural hematoma.
2. Herniation of uncus.
3. Brain stem hemorrhage.
4. Possible perforated neurogenic ulcer.

GENERAL CLINICAL DISCUSSION

DR. E. VON HAAM: Dr. Morton, do you have anything to add?

DR. J. L. MORTON: The x-ray pictures showed no clouding of the mastoids to indicate a basilar skull fracture. There was a little hyperostosis frontalis interna present which has no particular relationship to any known disease.

DR. LEFEVER: One x-ray report mentioned a demineralization of the tuberculum sellae. This usually implies the fact that the individual has harbored an increased intracranial pressure for a long period of time, but I don't think this has any significance in this case.

DR. MORTON: The posterior clinoid processes are not different when compared to other parts of the skeleton. This is some extra calcification around the anterior clinoids which I consider portions of a calcified vessel.

DR. LEFEVER: Would you consider the possibility of an aneurysm at that point?

DR. MORTON: It is a possibility but I do not think that it is a very great one.

DR. E. K. RYDER: How can it be explained that the spinal pressure was normal when it was taken before surgery?

DR. LEFEVER: That is one of the facts that in my opinion adds greatly to the theory that this patient may have harbored an uncal herniation. We know of several instances in which the spinal fluid pressure does not express the true intracranial pressure. Such is the case when there is a herniation of the tonsils of the cerebellum through the foramen magnum. Uni- or bilateral herniations of the uncus can also prevent an increase of intracranial pressure from being transmitted into the subarachnoid space of the spinal cord.

DR. E. M. HARD: Isn't it unusual that so long after her accident the spinal puncture still showed 372 red blood cells per cubic millimeter and no white blood cells?

DR. LEFEVER: No, I don't think so. We often find no cells at all, but the arachnoid membrane is very thin and sometimes permits the diffusion of a few red blood cells.

MEDICAL STUDENT: How about the possibility of rupture of some blood vessel in the lateral ventricle or in the brain substance?

DR. LEFEVER: Of course the patient was a hypertensive individual, but following surgery her blood pressure dropped to 132 and we can postulate on this basis thrombosis rather than hemorrhage. In case of hemorrhage the patient could not have moved all extremities as freely as she did following surgery.

PATHOLOGICAL DIAGNOSIS

1. Status 9 days post-evacuation of left subdural hematoma.
2. Encephalomalacia of left lobe of cerebellum.
3. Recent hemorrhage in left cerebral peduncle.
4. Hypertensive cardiovascular disease with left ventricular hypertrophy.

5. Purulent bronchitis with bronchopneumonia.
6. Ulceration of small intestine.
7. Status post-tracheotomy.

PATHOLOGICAL DISCUSSION

DR. VON HAAM: The patient was a very obese woman weighing 250 pounds. She had a large heart, which weighed 485 grams and was quite typical of long-standing hypertension. The coronary arteries revealed a few small plaques. Both lungs were heavy, weighing 445 and 600 grams. The trachea and bronchi contained a large amount of yellow creamy fluid; the mucosa was markedly injected throughout. The hilar lymph nodes were slightly enlarged, firm and black. The spleen was enlarged and soft, weighing 320 grams. The cut surface revealed a reddish-purple, mushy pulp.

The gastrointestinal tract showed a small ulcer of the duodenum. This ulcer, however, did not bleed nor had it perforated. It was of the acute type and we feel that it did not contribute to the death of the patient. Otherwise the autopsy showed no gross pathologic changes except in the brain.

THE BRAIN

The skull showed burr holes in both parietal bones and the area from which the hematoma was evacuated showed a thickened dura and some blood in a partial stage of organization still adherent to the dura. The brain weighed 1230 grams. The cerebral and cerebellar hemispheres were symmetrical. The convolutions over the superior aspect of the cerebrum were slightly depressed. There was a mild arteriosclerosis of the arteries at the base of the brain. No uncal herniation was noted but this could have been easily overlooked during the procedure of removing the brain. The anterior one-half of the cerebellum was very soft. Sectioning revealed a necrosis of the upper portion of the left cerebellum extending to the level of the white matter. There also was a sharply defined recent hemorrhage 7 millimeters in diameter in the left cerebral peduncle just below the substantia nigra. Sectioning of the cerebrum revealed no significant changes. The pituitary gland appeared normal.

MICROSCOPICAL

Microscopic examination of the heart showed marked hypertrophy of the heart muscle. The coronary arteries appeared in good condition. The microscopic examination of the lungs showed that the patient did have a rather severe regurgitation of food, which was accompanied by diffuse pulmonary atelectasis and a severe bronchopneumonia. It seemed that the suctioning through the tracheotomy wound did not function as it should. At the time of her death she had suffered practically complete pulmonary collapse. With high magnification I could identify all kinds of food matter, such as potato cells, etc. A severe inflammatory process was developing in both lungs. The liver showed a rather extensive necrosis of the liver cells which I considered fever necrosis. We have observed similar findings in patients who have died during fever therapy. It appeared in the form of multiple areas of focal necrosis, which we did not consider a fatal lesion.

Sections through the brain showed some remaining blood clots attached to the dura with beginning organization. The arachnoid membrane contained some inflammatory cells and macrophages with hemosiderin pigment. The cerebellum showed a rather recent area of encephalomalacia. The cerebellar peduncles and the brain stem showed petechiae and one conglomerate hemorrhage. The posterior cerebellar artery was thrombosed.

WHY SHE FELL

Dr. LeFever brought up the point of why she fell. Did she fall because she had a cerebral vascular accident or did she have the accident after she fell? Three weeks elapsed between her injury and her death. The microscopic appearance of the infarct suggested an approximate age of one to two weeks. It appeared slightly older than the lesions in the brain stem, which were quite recent. I was quite intrigued by Dr. LeFever's theory of an uncal herniation with increasing pressure on the vessels of the brain stem and interference with the normal circulation.

When we sectioned the posterior cerebellar artery we found a rather recent thrombus which appeared approximately one to two weeks old. My first interpretation was that of a postoperative traumatic thrombosis which initiated the fatal events in the patient. I feel now that Dr. LeFever's theory of an unrestored uncal herniation is perhaps more correct and I would like to ask Dr. LeFever to comment on this point. Do you think that surgical trauma in this patient could explain those cerebellar and brain stem lesions, or do you still feel that an unrestored uncus herniation would be a better explanation? If the latter surmise is correct, the patient died from a lesion which developed after her fall but before she was operated upon. If my former theory is correct we would have to ask ourselves to shoulder the blame for the fatal outcome.

GENERAL DISCUSSION

DR. LEFEVER: This is a most interesting case indeed. As I indicated, I am very familiar with the fact that uncal herniation will produce an impairment in the circulation of the posterior cerebral artery and will produce a necrosis just as precisely as you have observed in the cerebellum. However, it is new to me that an uncal herniation can occur to the extent that it might produce a thrombosis of the cerebellar arteries. I agree with Dr. von Haam that certain areas in the cerebellar necrosis appeared older than that in the stem. I think it unquestionably arose from the mechanism which we described here—

the uncal herniation. Do you recall which side the hemorrhage was upon?

DR. VON HAAM: Left.

DR. LEFEVER: Which is the same side as the subdural hematoma. Invariably hemorrhages in the brain stem will occur upon the same side from which the pressure is exerted. In uncal herniation one may observe an extradural collection of spinal fluid immediately beneath the tentorium. This collection of fluid may amount to 100 or 120 cubic centimeters and it will exert additional pressure upon the cerebellar area. I can visualize that the superior posterior cerebellar artery is in a position that it well could be the site of impingement as a result of extensive herniation. I do believe that the thrombosis occurred after the receipt of the injury and I cannot conceive of the trauma of surgery being in any way responsible for it. The site of surgery was too far removed and usually the brain is not damaged during this type of operation.

MEDICAL STUDENT: Can postoperative shock explain the thrombosis of the cerebellar artery?

DR. LEFEVER: When the blood pressure of an individual drops abruptly a tendency for thrombosis may develop. Particularly vessels which branch off at a sharp angle are very sensitive to sudden changes of pressure.

DR. VON HAAM: We should not forget that the immediate cause of death in this patient was the severe anoxia produced by aspiration of food with pulmonary atelectasis and bronchopneumonia.

LITERATURE

Grinker, R. R.. and Bucy, P. C.: Neurology, Springfield, Ill., Charles C. Thomas Co., 1949, pp. 832-834.

Dizziness from the Viewpoint Of the Internist

Asthenia, headache and dizziness in the housewife should always bring to mind chronic carbon monoxide poisoning, as well as psychoneurosis and menopause (probably our most frequently overworked explanations).

Motion sickness may be a cause for continuing and recurring dizziness. In adults the patient can usually recognize the clear cut relationship. In children it may at times be puzzling but usually not in relationship to vertigo or dizziness as the complaint but as recurring nausea, pallor, weakness and sweating in the child.

As a part of the general systemic response to some allergenic substances dizziness is often observed. This is distinct and separate from the statement by some that Ménière's syndrome may be due specifically to allergic edema of the labyrinth.—Vince Moseley, M.D., Charleston, S.C.: *J. South Carolina M.A.*, 50:95, April, 1954.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Calisthenics—Now designating the art of promoting bodily health by exercise, this term originally designated mild exercises which were recommended to promote bodily beauty for the fairer sex. The term comes from the Greek words "kalos," or beautiful, and "sthenos," or strength.

Ease—The Latin word "ansa" means a handle and the Latin word "ansatus" is used to refer to a man with his arms akimbo because he looks as though he had handles. Because a man with his arms akimbo is idle he therefore is a man at "ease." From this came the French word "aise," meaning satisfaction, from which we derive our English word "ease." The word ease has now become extended to mean freedom from pain, want or hunger.

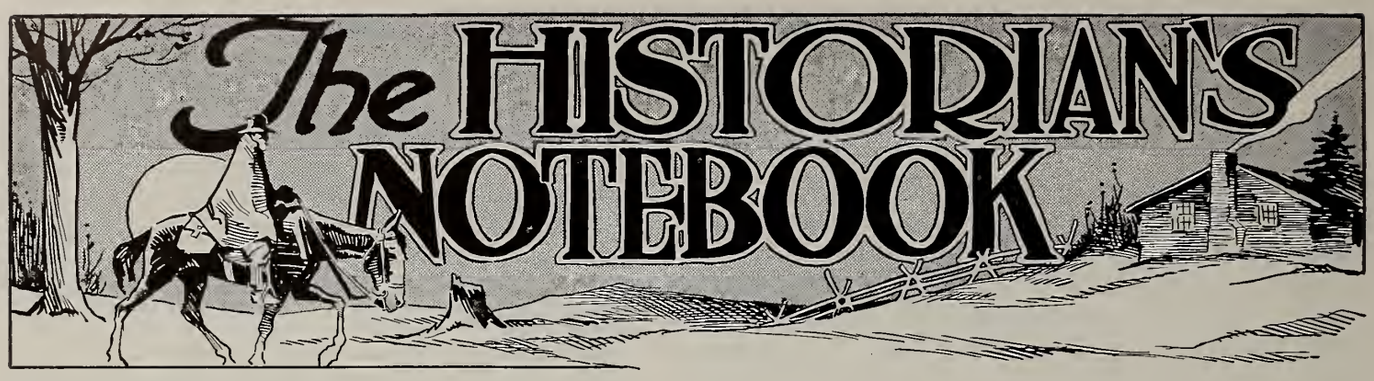
Caisson Disease—Also known as the "bends" and "diver's palsy," this disease is produced in individuals who, after having breathed air under a pressure of considerably more than one atmosphere, are subjected to unduly rapid reduction of air pressure. The disease was described in 1841 by Triger, a French engineer, who first employed a caisson in 1839. Caissons are box-like compartments used in underwater construction work such as bridge and tunnel building, and the name comes from the French word "caisse" meaning a box or coffer.

Hamate Bone—Formerly called the unciform bone, this is the most ulnar of the distal row of carpal bones. This bone was so named from the hook-like process which projects from its volar surface and the name is derived from the Latin word "hamatus," meaning hooked or crooked.

Sassafras—This mild aromatic stimulant has a name which literally means "stone-breaker." The term is a corruption of the earlier words "sassifragia" and "saxifragia" which are derived from the Latin words "saxum," or stone, plus "frangere" meaning to break. The drug was supposedly so named because the ancients used it as a treatment for bladder stones. It has also been suggested that the name may have resulted from the fact that the plant frequently sprouts or grows in the clefts of rocks and thus gives the appearance of having broken the stone or rock.

Ephelides—Ephelis—Because the ancient Greeks noted that freckles were more common and prominent in the sunny season, they called them "ephelides," a term literally meaning "on or from the sun". These terms are derived from the Greek words "ep," or on, and "helios," or sun.

—HARRY WAIN, M. D., Mansfield, Ohio.



A Country Doctor in Germany Has Found A Germ Is the Cause of Consumption

JONATHAN FORMAN, M.D.

This Disease is also propagated by Infection. For this Distemper, as I have observed by frequent Experience, like a contagious fever doth infect those that lie with the Sick Person with a certain taint, —wrote Morton in *Phthisologia*, p. 67, nearly 275 years ago.

As a teacher of medical history, I have always felt that it is more important that the medical student come to appreciate the impact upon our own citizens in Ohio of the discoveries than that I talk with him about the ancients, or about the lives of the discoverers.

One of the interesting illustrations of this point is the way the news that a country doctor in Germany had discovered a germ which he said was the cause of consumption.

BACKGROUND

Before the germ theory of the cause of disease had become established, the medicine of the nineteenth century was under the influence of the German physiologic school. The leaders of this school looked upon structure and function as a unit. They concentrated their efforts upon laws which govern the behavior of the living organism in disease. As Virchow wrote, "Disease is nothing but life under altered conditions." Magendie had long before announced the same principle when he said, "Pathology is the physiology of the diseased individual."

Even prior to this, the great majority of diseases had been identified and sufficiently well described to be recognized when they were seen in a well-advanced state.

This German physiological school had been based upon the Parisian anatomic school's studies of structural pathology.

We may therefore say that steps which led up to the subject under discussion began with the identification and naming of the various major diseases, a growing appreciation of the structural and functional changes of each of these diseases.

Virchow, following the stimulus of his teacher, Johannes Müller, focused attention on the histology of pathology. As a result, he could not accept the specificity of disease as it had been proposed. Consequently, he was totally unprepared for the results of the new discoveries of bacteriology. He therefore came into direct opposition with Koch. If such a great scientist as Virchow was not able to keep pace with the changes which were taking place in Medicine, there is no blame upon the local physicians in Columbus who were slow to accept the germ theory of the etiology of tuberculosis.

In the beginning of the nineteenth century the theory of the contagiousness of tuberculosis was not generally accepted. Rather, an inherited predisposition was looked upon as the basis of disease. By 1866, Jean Antoine Villemin showed that tuberculosis could be transmitted from man to animals and from one animal to another. Thus, the ground work was laid for the discoveries of Robert Koch who in 1882 reported his investigations on the germ of tuberculosis. In that paper, Koch, who was a pupil of Jakob Henle, subjected his studies to the criteria formulated by his teacher. From that day to this, however, these are spoken of as Koch's Postulates.

COLUMBUS IS APPR'SED

One of the most progressive and certainly the best-read of the Columbus physicians in 1882 was D. N. Kinsman. For years he subscribed to and read the German and French medical journals and kept relaying the facts which he learned to the physicians of Ohio in paper after paper, lecture after lecture. At the 36th Annual Meeting of the Ohio State Medical Society, held at Columbus on June 14, 15, and 16, 1881, he read a paper entitled "The Etiology of Consumption." He began this discussion as follows:

"Morton in his treatise on Consumption treated

of eleven varieties, basing his division upon their etiology. Bayle classifying on the basis of morbid anatomy described five kinds. Laënnec reduced all forms to one, i.e., tubercular."

"Reinhardt and Virchow led a revolt against this exclusive view and made two divisions. Niemyer threw his influence on this side. Opinions at the present seem to be tending toward the adoption of Laënnec's views and the idea of the unity of the disease."

His thesis was that "Too much stress has been placed upon the presence of the anatomical entity known as tubercle, and too little account has been taken of the condition tuberculosis, which must precede the tubercular eruption." He defends this thesis with some 18 pages with scores of illustrative case histories. He concludes:

"Tuberculosis does not, therefore, arise de novo, but depends upon a germ, introduced into the organism at its inception or subsequently from without. Concerning the nature of this germ, we are in the dark.

"The recent announcement of Koch, if confirmed by other experimenters as has been done by Baumgarten, will throw light upon this obscure field, and we may hope that consumption will become subject to hygienic precautions. When to these measures is added the modified treatment which must necessarily arise out of new views of the etiology of consumption we may hope to attain as fair a success in its treatment as we have already reached in the treatment of other infectious diseases."

The next year, at the 38th Annual Meeting of the Ohio State Medical Society, held at Cleveland, on June 5th, 1883, Dr. Kinsman gave a Report on Tuberculosis, in which he reviewed the bacteriologic studies of Klebs (1877), Reinstadler, Deutschmann, Toussaint and Baumgarten leading up to "the masterly investigations of Dr. Robert Koch." He reported briefly some 36 cases of consumption in which he demonstrated the bacilli in 32 instances and gave good reason why the germs could not be found in the other four.

These two papers by Dr. Kinsman were the only papers on tuberculosis presented before the Ohio State Medical Society during the five years following the appearance of Koch's report.

In the July issue of *The Columbus Medical Journal* (Vol. I, No. 1, p. 48), in an editorial from *The New York Record*, "that Koch's experiments have excited much more talk than they deserve, and we confess to some skepticism in regard to the facts and still more as to their 'far-reaching significance.' New York microscopists have not yet been able to find the bacilli."

"The professional mind has for some years been in a feverish condition of hope created by the developments and their possibilities, in connection with bacteria. It has felt that it was on the confines of some great scientific fact which should be utilized with incalculable service in the healing of the nations. The eye of expectancy has been directed towards the Pasteurs, the Tommasi-Crudellis, the Kochs, the Woods, the Formads and the Sternbergs, who have conducted us to heights from which we have been well nigh able to discern the promised land."—Quotation from *Louisville Medical News*, in *Columbus Medical Journal*, Vol. 1, 1882-83, p. 413.

No papers on tuberculosis appeared in *The Columbus Medical Journal*, Vols. I, II, III, 1882-85. In Volume V, p. 303, *Columbus Medical Journal*, "An Easy and Reliable Method of Demonstrating the Tubercle Bacillus," taken in detail from Dr. Jas. E. Reeve's on *How to Work with the Microtome*, publisher, Bausch & Lamb, Rochester, N.Y. This is the first and only paper on the tubercle bacillus that appeared in *The Columbus Medical Journal* during the first five years after Koch had made his report.

(To Be Continued)

History's Examples of Effectiveness Of Biological Agents in Warfare

History contains many examples of the effectiveness of biological agents in defeating armies. On the plains of Thessaly, epidemics killed nearly two-fifths of Xerxes' 800,000 troops. Plague and typhus slaughtered the Crusaders at the gates of Antioch and Jerusalem. Typhus liberated Granada from the Moors. Typhus and dysentery decimated Napoleon's grand army in Russia. These epidemics were natural in origin, and the populations at risk had little or no preventive measures. Even without the latter, a considerable time factor is involved in the spread of epidemic disease on this vast scale. Perhaps the earliest deliberate attempts to spread disease among the enemy was the practice sometimes used in the Middle Ages of dropping plague-ridden corpses into the village wells.

During World War I, German secret agents in the United States infected livestock about to be shipped to the Allied Nations of Europe with glanders. Although these a tacks were crude, they indicated the possibility of using this weapon in the form of sabotage.

During World War II the possibility of widespread dissemination of disease organisms was recognized. In order to provide the proper defense mechanisms against this form of attack, it was necessary to have some fundamental knowledge. This could only be obtained by an extensive research program. Accordingly in the summer of 1942, the War Research Service was organized as part of the Federal Security Agency. —John Beeston, M. B., D. P. H., Los Angeles: *California Medicine*, 79:25, July, 1953.

Proceedings of The Council . . .

Two Busy Sessions Held During Annual Meeting in Columbus; Committees for the Ensuing Year Appointed by Dr. Prugh and Confirmed by Council

A MEETING of The Council of the Ohio State Medical Association was held on Sunday evening, April 11, at the Neil House, Columbus, Ohio, on the eve of the opening of the 1954 Annual Meeting of the Association. In addition to members of The Council, also present were a number of past-presidents, committee chairmen and representatives of the Columbus Academy of Medicine, the host society for the annual meeting. Following a social hour and dinner, The Council held a short business session.

The minutes of the last meeting of The Council held on March 27-28, were approved on **motion** duly made, seconded and **carried.**

MEMBERSHIP STATISTICS

Membership statistics were presented by the Executive Secretary as follows:

Ohio State Medical Association membership as of April 9, 1954—7,706, compared to a total membership of 8,068 as of December 31, 1953.

American Medical Association membership as of April 9, 1954—6,712, compared to a total of 6,941 who were 1953 A.M.A. members.

PAST-PRESIDENTS HONORED

At the time of the introduction of guests, Dr. Davis presented a past-president's button—an innovation—to the following past-presidents: Doctors A. A. Brindley, Toledo, Fred W. Dixon, Cleveland, Carl A. Lincke, Carrollton, H. M. Platter, Columbus, L. Howard Schriver, Cincinnati, C. C. Sherburne, Columbus, Wm. M. Skipp, Youngstown, and C. W. Waggoner, Toledo. It was agreed that emblems for past-presidents who were unable to be present would be turned over to members of The Council for them to present the button to such past-presidents personally or at some meeting to be arranged by the local medical society to which the past-president belongs.

The Executive Secretary reviewed Annual Meeting events.

POLIO VACCINE PROGRAM

Dr. John D. Porterfield, one of the guests at the meeting, spoke briefly regarding the polio vaccine test program in Ohio, calling attention to the confusion created by the broadcast by Walter Winchell. Dr. Porterfield stated that he was still of the opinion that the safety tests are entirely adequate and felt that the test program should proceed as planned.

On **motion** made, seconded and **carried,** The Council approved a recent statement made to the press by President Davis on this subject, which statement read as follows:

> "Confidence that adequate safeguards have been established in the production and distribution of the vaccine which will be used in the voluntary polio prevention test program in Ohio, and throughout the country, was expressed today by Dr. Paul A. Davis, Akron, president of the Ohio State Medical Association. Plans have been made for the program in Richland, Summit and Montgomery counties.
>
> "Dr. Davis stated that The Council of the Ohio State Medical Association on December 3, 1953, voted the cooperation and assistance of the Association to Ohio public health officials in conducting the polio test program in Ohio, after receiving assurances from state and national public health and medical authorities that rigid safeguards had been set up in the manufacture and use of the vaccine.
>
> "Dr. Davis pointed out that The Council of the Association had not met since a broadcast by Walter Winchell raising questions about the vaccine and that, therefore, the official action taken by the Association's governing board remained in effect.
>
> "The officials of the State Medical Association, in the opinion of Dr. Davis, have complete confidence in the competency and honesty of public health and medical authorities in charge of the program, including Dr. John D. Porterfield, Ohio Director of Health; U. S. Public Health Service officers; and medical authorities of the National Foundation for Infantile Paralysis.
>
> "Dr. Davis said he could not speak for other officials of the Association but he expressed the opinion that they would take the position that the assurances which had been made by those handling the details of the program will be complied with—namely, that no vaccine will be released for use until it has passed rigid tests and found to be safe."

HOSPITAL RELATIONS

A letter from Dr. Frank C. Sutton, Director, Miami Valley Hospital, Dayton, suggesting the formation of a liaison committee by the Ohio State Medical Association and the Ohio Hospital Association for the purpose of discussing and conferring on questions of mutual interest and importance, was read.

By official action, The Council referred this to the newly created Committee on Hospital Relations, successor to the Committee on Accreditation of Hospitals. Dr. Prugh announced that the personnel of this committee would be

reported to The Council at its meeting on Thursday, April 15.

DRUG BILL APPROVED

A communication from the Ohio State Pharmaceutical Association, requesting endorsement of H.R. 7817, now pending in the Congress, was read and discussed. H.R. 7817 would authorize the acceptance of oral prescriptions for non-habit forming compounds of codeine and other narcotic drugs and would authorize the Secretary of the Treasury to establish a list of compounds for which oral prescriptions would be allowed. It was pointed out that this proposal had the endorsement of the American Medical Association, in addition to other medical and pharmaceutical organizations. On motion made, seconded and carried, The Council endorsed H.R. 7817.

DR. DAVIS THANKED

A motion presented by Dr. Heusinkveld and duly seconded, thanking and commending Dr. Davis for his fine work and untiring services during his tenure of office, was adopted unanimously by a rising vote.

A detailed breakdown on membership by districts and by counties and copies of the annual audit of the books of the Association and *The Journal* by Keller, Kirschner, Martin & Clinger, certified public accountants, for the calendar year 1953, were presented to members of The Council.

The Council then recessed to meet with the House of Delegates on Monday evening, April 12.

SESSION HELD ON APRIL 15

A MEETING of The Council of the Ohio State Medical Association was held Thursday, April 15, 1954, at the Neil House, at the conclusion of the final session of the House of Delegates.

All members of The Council were present except newly elected Councilors, Dr. C. T. Atkinson, Middletown, and Dr. Robert E. Hopkins, Coshocton.

SCIENTIFIC WORK COMMITTEE COMMENDED

The first action of The Council was to adopt a motion highly commending the Committee on Scientific Work and Dr. George J. Hamwi, Columbus, Director of the Scientific and Educational Exhibit, on the splendid program and exhibits arranged for this year's meeting. The Executive Secretary was authorized to convey this information to members of the committee and to Dr. Hamwi.

Dr. Prugh requested members of The Council to come to the May 23 meeting in Columbus prepared to offer criticisms, suggestions and ideas regarding the program and the setup for the 1955 Annual Meeting.

COMMITTEE APPOINTMENTS

Dr. Prugh then announced the following committee appointments, all of which were confirmed by The Council, and at the same time he requested members of The Council to offer suggestions from time to time for additions to these committees:

Committee on Auditing and Appropriations—Robert S. Martin, Zanesville, chairman; E. H. Artman, Chillicothe; Charles L. Hudson, Cleveland.

Committee on Blood Banks—Horace B. Davidson, Columbus, chairman; Russell B. Crawford, Lakewood; John B. Hazard, Cleveland; Alfred E. Rhoden, Toledo; Robert J. Ritterhoff, Cincinnati; H. Verne Sharp, Akron; Warren E. Wheeler, Columbus.

Committee on Chronic Illness—Harry V. Paryzek, Cleveland, chairman; H. W. Brettell, Steubenville; Ralph E. Dwork, Columbus; Gordon L. Erbaugh, Dayton; Jonathan Forman, Worthington; Joseph I. Goodman, Cleveland; Nelson D. Morris, Toledo; H. J. Nimitz, Cincinnati; Carl S. Nohe, Akron; Frank A. Riebel, Columbus; Stanley D. Simon, Cincinnati; John L. Stifel, Toledo. **Subcommittee on Cancer**—C. E. Hufford, Toledo, chairman; Arthur G. James, Columbus; John H. Lazzari, Cleveland; Frank T. Moore, Akron; W. D. Nusbaum, Lancaster; A. E. Rappoport, Youngstown; Walter A. Reese, Middletown; Carl A. Wilzbach, Cincinnati; W. E. Wygant, Mansfield. **Subcommitttee on Mental Hygiene**—Dwight M. Palmer, Columbus, chairman; Calvin L. Baker, Columbus; Edward O. Harper, Cleveland; Elmer Haynes, Toledo; Maurice Levine, Cincinnati; Roger E. Pinkerton, Akron; J. E. Sagebiel, Dayton.

Committee on Hospital Relations—George A. Woodhouse, Pleasant Hill, chairman; Paul F. Orr, Perrysburg; Robert S. Martin, Zanesville; Fred W. Dixon, Cleveland; Philip B. Hardymon, Columbus.

Committee on Industrial Health and Workmen's Compensation—H. P. Worstell, Columbus, chairman; Warren A. Baird, Toledo; A. L. Berndt, Portsmouth; A. L. Bershon, Toledo; Harold James, Dayton; Louis N. Jentgen, Columbus; Edmund F. Ley, Tiffin, Joseph Lindner, Cincinnati; R. L. Rutledge, Alliance; John M. Van Dyke, Canton; Rex H. Wilson, Akron; James N. Wychgel, Cleveland.

Committee on Interprofessional Relations on Eye Care—Arthur Collins, Cleveland, chairman; Claude S. Perry, Columbus; W. Max Brown, Mansfield.

Committee on Legislation—Frank H. Mayfield, Cincinnati, chairman; W. W. Trostel, Piqua; Floyd M. Elliott, Ada; D. J. Slosser, Defiance; George W. Petznick, Cleveland; Wm. M. Skipp, Youngstown; Jay W. Calhoon, Uhrichsville;

James B. Johnson, Jr., Newark; Clyde M. Fitch, Portsmouth; Donald F. Bowers, Columbus; R. L. Mansell, Medina.

Committee on Maternal Health—Anthony Ruppersberg, Jr., Columbus, chairman; J. H. Bane, New Concord; John Y. Bevan, Steubenville; Richard D. Bryant, Cincinnati; Herbert D. Chamberlain, McArthur; Gordon L. Erbaugh, Dayton; Glen K. Folger, Cleveland; John F. Hillabrand, Toledo; Frederic G. Maurer, Jr., Lima; Richard L. Meiling, Columbus; Wm. J. Pittenger, Akron; Herbert W. Salter, Cleveland; Dean E. Sheldon, Sandusky.

Committee on National Emergency Medical Service—Drew L. Davies, Columbus, co-chairman; C. C. Sherburne, Columbus, co-chairman; A. A. Brindley, Toledo, member-at-large; Robert Conard, Wilmington, member-at-large; Richard L. Meiling, Columbus, member-at-large; Herbert B. Wright, Cleveland, member-at-large. **Subcommittee on Civil Defense**—C. C. Sherburne, Columbus, chairman; Robert D. Mansfield, Cincinnati; G. G. Floridis, Dayton; Charles H. Leech, Lima; Richard Hotz, Toledo; A. Macon Leigh, Cleveland; Earl A. Simendinger, Akron; F. B. Harrington, Steubenville; J. F. Morton, Zanesville; Francis W. Shane, Gallipolis; Paul W. Smith, Lorain. **Military Advisory Subcommittee**—Drew L. Davies, Columbus, chairman; Robert Conard, Wilmington, member-at-large; David A. Tucker, Jr., Cincinnati; Homer D. Cassel, Dayton; Lester C. Thomas, Lima; A. A. Brindley, Toledo; Donald M. Glover, Cleveland; R. L. Rutledge, Alliance; Albert T. Winston, Steubenville; Walter L. Cruise, Zanesville; Garnett E. Neff, Portsmouth; E. L. Montgomery, Circleville; Charles R. Keller, Mansfield.

Committee on Rural Health—E. K. Yantes, Wilmington, chairman; L. E. Anderson, Greentown; Byron B. Blank, DeGraff; E. G. Caskey, Mineral Ridge; Jonathan Forman, Worthington; V. R. Frederick, Urbana; Carl F. Goll, Steubenville; L. W. High, Millersburg; H. R. Mayberry, Bryan; Carll S. Mundy, Toledo; W. L. Murphy, Cardington; J. I. Rhiel, Port Clinton; James M. Snider, Marysville; G. N. Spears, Ironton; H. K. Van Buren, Carey; D. S. Williams, Marietta: Kenneth Taylor, Pickerington.

Committee on School Health—Thomas E. Shaffer, Columbus, chairman; Carl A. Wilzbach, Cincinnati; Robert A. Lyon, Cincinnati; Walter Felson, Greenfield; T. L. Light, Dayton; Charlotte L. Ames, Xenia; W. F. Galbreath, Findlay; D. L. Steiner, Lima; Margaret E. Belt, Lima; William S. Rothe, Bowling Green; Howard H. Hopwood, Jr., Cleveland; J. M. Painter, Kent; Robert M. Lemmon, Akron; Russell L. Oyer, Sugarcreek; Margaret O'Neal, Zanesville; Carl L. Petersilge, Newark; H. B. Thomas, Gallipolis; J. W. Wilce, Columbus; Walter F. Heine, Circleville; Henry L. Sowash, Sandusky.

Woman's Auxiliary Advisory Committee—Carl A. Gustafson, Youngstown, chairman; James R. Jarvis, Van Wert; C. L. Pitcher, Portsmouth.

There being no further business, The Council adjourned to meet Sunday, May 23, Columbus office, 9 a.m., Eastern Standard Time.

Attest: CHARLES S. NELSON,
Executive Secretary

WHAT TO WRITE FOR

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

Safety for the Household. A publication of the National Bureau of Standards, U. S. Department of Commerce, designed to serve as a reference book on hazards commonly encountered in the household, and how to eliminate them. Catalog No. C13.4:463, Superintendent of Documents, Government Printing Office, Washington, 25, D. C. Price, 75 cents.

* * *

Facts About Nursing. The 1953 edition, providing statistics about nurses, nursing, and selected health facilities, prepared by the American Nurses' Association. Includes data on professional and nonprofessional nurse distribution and resources, educational facilities, licensure, etc. From American Nurses' Association, 2 Park Avenue, New York, 16. Price, One dollar.

* * *

Housekeeping Training Guides. For hospital employees. Using cartoon characters these booklets show how to clean easily and efficiently and illustrate use of special equipment. The books discuss sweeping, mopping, dusting, and waxing, respectively. "Sweepy," (TG 10-2) 25 cents; "Moppy" (TG 10-3) 30 cents; "Dusty" (TG 10-4) 20 cents; "Waxey" (TG 10-6) 30 cents, from Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

* * *

Report of Fourth National Conference on Physicians and Schools. Just printed, this book not only reports on the fourth conference, but also, presents compact reviews of the first, second, and third. Must reading for members of county medical society school health committees and all physicians interested in school health. Available without charge from the Bureau of Health Education, American Medical Association, 535 N. Dearborn St., Chicago 10, or from the Committee on School Health, Ohio State Medical Association, 79 E. State Street, Columbus 15.

Past-Presidents of Association Receive Buttons



Left to right, are: Drs. Waggoner, Lincke, Skipp, Dixon, Platter, Clodfelter, Davis, Brindley, Sherburne and Schriver.

First Emblems Given at Council Meeting, Others To Be Presented Later

The Council at a recent meeting authorized presentation of a Past-President's Button to be given to surviving physicians who have served in that high office of the Ohio State Medical Association.

Buttons were presented at The Council meeting on the eve of the Annual Meeting to Past-Presidents in attendance. They are: Dr. C. W. Waggoner, Toledo, 1930-1931; Dr. H. M. Platter, Columbus, 1932-1933; Dr. William M. Skipp, Youngstown, 1940-1941; Dr. C. C. Sherburne, Columbus, 1943-1944; Dr. L. Howard Schriver, Cincinnati, 1944-1946; Dr. A. A. Brindley, Toledo, 1948-1949; Dr. Carl A. Lincke, Carrollton, 1949-1950; Dr. Fred W. Dixon, Cleveland, 1951-1952; Dr. Harve M. Clodfelter, Columbus, 1952-1953; Dr. Paul A. Davis, Akron, received his pin after he relinquished his office at the last meeting of the House of Delegates.

Others eligible to receive emblems are: Dr. J. H. J. Upham, Columbus, 1914-1915; Dr. Robert Carothers, Cincinnati, 1922-1923; Dr. C. D. Selby, Port Huron, Mich., 1925-1926; Dr. Clyde L. Cummer, Cleveland, 1933-1934; Dr. John A. Caldwell, Cincinnati, 1934-1935; Dr. Parke G. Smith, Cincinnati, 1939-1940; Dr. Harry V. Paryzek, Cleveland, 1941-1942; Dr. Edward J. McCormick, Toledo, 1942-1943; Dr. R. L. Rutledge, Alliance, 1947-1948; Dr. E. O. Swartz, Cincinnati, 1950-1951.

Arrangements are being made to have presentations to these Past-Presidents through their local Medical Societies.

Dr. Forman Takes Part in Community Projects

Dr. Jonathan Forman, Editor of *The Journal*, has taken a leading role in a number of community projects recently, among which are following for the month of April:

He arranged a watershed management conference for the State of Kansas, and presided at the session at Topeka, Kansas.

As past-president, he attended the 10th Annual Congress of the American College of Allergists in Miami, Fla.

He was a guest speaker before the National Meeting of the American Academy of Nutrition, where he spoke on trace minerals in nutrition at one session and on soil, food and health at another. The following day, he talked before the lay organization, the American Nutrition Society, on "Health Comes from the Farm." Both sessions were held at Pasadena, California.

He addressed the Food and Drug Chemists of the Southern States in Atlanta, Ga., on the relation of agriculture to health.

He is taking an active role as chairman of a special Committee of the Columbus Chapter of Friends of the Land which has begun a long range program in the education of the people on the Scioto River watershed in the wise use of the water supply.

In May, he attended a meeting of a special committee on watershed management in Philadelphia.

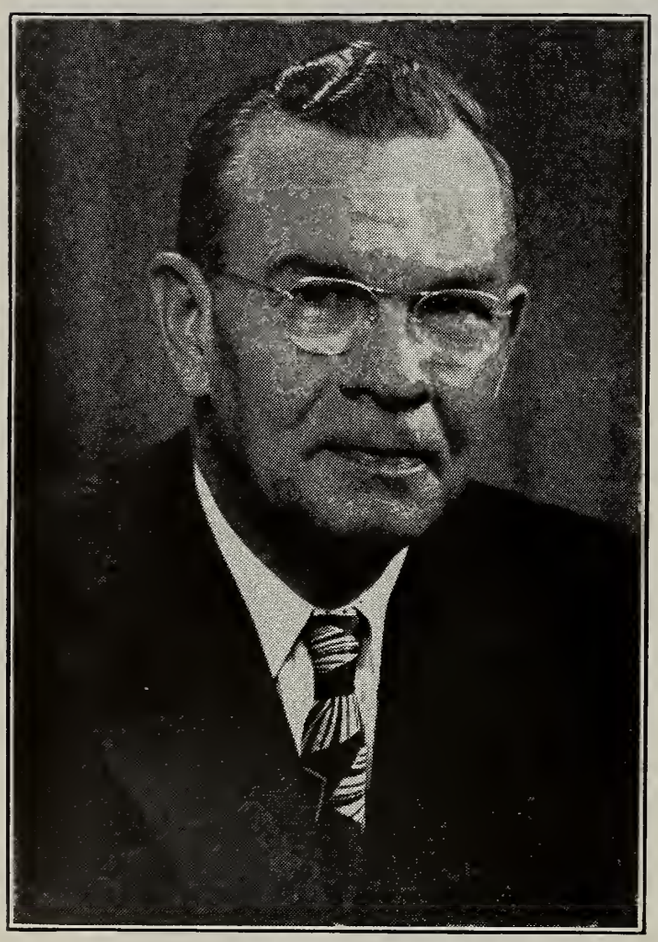
He accepted a position on Governor Lausche's Water Management Commission Task Force in exploring the problem as to how to give a motivating understanding of the wise use of rain on the part of the people of Ohio.

Presenting . . .

The New President-Elect and Three New Councilors of the Association Named by the House of Delegates at the Annual Meeting in Columbus

THE House of Delegates elected a new President-Elect and three new Councilors at the Annual Meeting of the Ohio State Medical Association in Columbus, April 12-15. Following are biographical sketches of these new officers as well as information about other members of The Council.

Dr. David W. Heusinkveld, Sr., Cincinnati, was named President-Elect of the Ohio State Medical Association after serving five years on The Council as Councilor of the First District. He will assume the Presidency at the 1955 Annual Meeting in Cincinnati.



DAVID W. HEUSINKVELD, SR., M. D.

Dr. Heusinkveld comes to this office with a rich background of experience in medical, health and community organization work.

A native of Fulton, Illinois, he crossed the Mississippi River for four years to attend high school in Clinton, Iowa. He attended Hope College, Holland, Michigan, for two years before entering the Armed Services and serving as an Infantry Officer. He later transferred to the University of Chicago where he received his B.S. degree in 1921.

Dr. Heusinkveld received his M. D. degree from Rush Medical College, University of Chicago, in 1924 and the following year pursued his intern training at Cincinnati General Hospital. He began private practice in Cincinnati in 1925, specializing in diseases of the chest and received certification in 1938 as a specialist in pulmonary diseases.

He is assistant clinical professor of medicine in the University of Cincinnati College of Medicine, director of chest service in Good Samaritan and on the staffs of Bethesda and Dunham Hospitals. He also serves as roentgenologist for the Cincinnati and Hamilton County Health Departments.

Dr. Heusinkveld is a past-president of the Academy of Medicine of Cincinnati and has served on several committees of that organization. He is a former president of the Hospital Care Corporation, the Blue Cross plan of the Cincinnati area, and served as a member of the Board of Trustees of the Cincinnati Chamber of Commerce for two years.

An ardent supporter of organizations fighting tuberculosis, he is currently president of the Ohio Tuberculosis and Health Association, and a past-president of the Cincinnati Anti-Tuberculosis League; also chairman of the Christmas Seal Committee of the Cincinnati League for the past ten years.

He has served as Governor for the Ohio Chapter of the American College of Chest

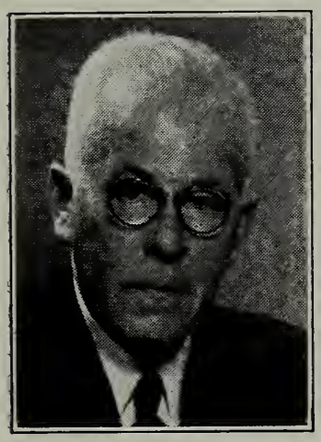
Physicians and is a member of the American Trudeau Society and the Ohio Trudeau Society. He also is a member of the American Medical Association and a member of the University Club of Cincinnati.

Dr. and Mrs. Heusinkveld are the parents of two sons, Dr. David W. Heusinkveld, Jr., now serving his country as a flight surgeon in Germany, and Kennon D. Heusinkveld of New York City.

Following are biographical sketches of the incoming President and newly elected Councilors as well as information about other members of The Council.

INCOMING PRESIDENT

Dr. Merrill D. Prugh, Dayton, was officially installed as President of the Association at the Annual Meeting. He was named President-Elect at the Annual Meeting in Cincinnati last year after serving four years on The Council as Councilor of the Second District.



M. D. PRUGH, M. D.

A native of Preble County, Dr. Prugh received his preparatory schooling in the public schools and then attended Miami University, Oxford, where he received his A. B. degree. He received the Doctor of Medicine degree from Hahnemann Medical College in 1909, after which he took an internship at Genessee Valley Hospital, Rochester, N. Y. He did postgraduate work in surgery at the University of Edinburgh, Scotland, and at the London (England) Postgraduate School of Surgery.

In 1911 Dr. Prugh established his practice in Dayton and has practiced there continuously since, with the exception of time served during World War I with the Medical Corps overseas. He attained the rank of Captain and later was commissioned a Major in the Medical Reserve corps.

For the first 25 years he practiced general medicine, but since 1936 has limited his field to general surgery. He is a member of the Dayton Surgical Society and a Fellow of the American College of Surgeons. Hospital affiliations include membership on the staff of Good Samaritan Hospital and the position as chief of the surgical staff at College Hill Hospital.

Dr. Prugh is a past-president of the Montgomery County Medical Society and served eight years as delegate of that society to the State Association. Also he served on local committees, and during World War II, was on the State Association's Procurement and Assignment Committee. He is a member of the American Medical Association.

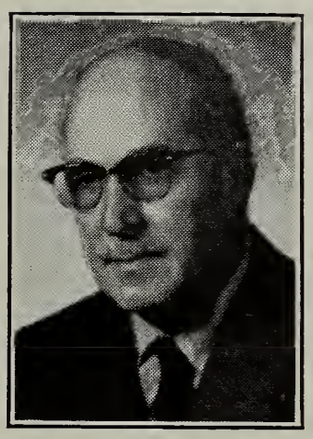
In 1949, Dr. Prugh was honored by his Alma Mater by being named most outstanding alumnus of Miami University.

Dr. and Mrs. Prugh have two sons Dr. Reed C. Prugh, who is associated in practice with his father, and Dan Prugh, in the manufacturing business in Dayton.

FIRST DISTRICT

Dr. Charles T. Atkinson, Middletown, was elected Councilor of the First District to succeed Dr. Heusinkveld.

Dr. Atkinson opened his practice in Middletown in 1918 and has been practicing there since with the exception of time he was away in military service. Born in Glouster, Ohio, in 1894, he received his medical degree from Ohio State University College of Medicine in 1916 and took his internship at St. Elizabeth Hospital, Dayton. During World War I, he served as an officer with the Army Medical Corps.



C. T. ATKINSON, M. D.

A general practitioner for his entire career, Dr. Atkinson was one of the first physicians to be certified by the American Academy of General Practice. He has been for a long time chief of medical service at the Middletown Hospital.

Long active in the Butler County Medical Society, Dr. Atkinson has served for a number of years on the Executive Council of the local organization. He has been active also on a number of County Society committees, among them the Legislative, Public Relations and Civil Defense Committees.

He is a long-time delegate of the local society to the Ohio State Medical Association. Recently he served as a member of the Committee on School Health of the O. S. M. A.

Active in community affairs, he is a member of the American Legion, the Methodist Church and numerous Masonic bodies, including the Shrine. He has served on the local Selective Service Board since the beginning of World War II.

Mrs. Atkinson is active in the local Woman's Auxiliary. The couple's one son is now

doing postgraduate work at the University of Pennsylvania.

SEVENTH DISTRICT

Dr. Robert E. Hopkins, Coshocton, was elected Councilor of the Seventh District to succeed Dr. R. J. Foster, New Philadelphia, who had served the maximum of three terms in that office.



R. E. HOPKINS, M. D.

Dr. Hopkins has served the Coshocton community continuously since 1931, having opened his practice there following medical training in Cleveland.

Born in Lorain, January 28, 1904, he pursued his premedical studies in Granville where he attended Doane Academy and Denison University, graduating in 1924 with the B. Sc. degree.

In 1924 he matriculated at Western Reserve University School of Medicine where he was elected to membership in Alpha Omega Alpha in his senior year. He graduated with the degree of M. D. in 1928. Intern training followed at St. Vincent Charity Hospital, Cleveland. Upon completion of his internship, he remained for two further years as assistant resident and resident in surgery. Later, during his practice, he took postgraduate work at the Cook County Hospital and the Roswell Park Memorial Institute. His professional work includes membership on the active staff of the Coshocton County Memorial Hospital and on the consulting surgical staff of the Pomerene Memorial Hospital, Millersburg. He is a Fellow of the American College of Surgeons.

His 23 years of professional service in Coshocton has been supplemented by medical organization work and by participation in community groups. He is a past-president of the Coshocton County Medical Society, and is a Fellow of the American College of Surgeons.

Membership in community organizations include the Coshocton Baptist Church, the local Rotary Club and the Masonic order. Dr. Hopkins is married and has two children.

ELEVENTH DISTRICT

Dr. Horatio Thomas Pease, Wadsworth, was elected Councilor of the Eleventh District to succeed Dr. John S. Hattery, Mansfield, who had served the maximum of three terms in that office.

A little before the turn of the century, Horatio Pease was born in a log cabin along the Oconee River in Georgia, his mother being from an old Southern family and his father a Connecticut Yankee. He was about six weeks old when his father decided to leave the 128 acre farm and go as a missionary to Norway. There in the land of the midnight sun, he spent the next six years of his life.

On returning to the United States in 1909, he attended school in various places in Georgia, Tennessee and finally in Ohio where he graduated from Minerva High School.

After serving in the Army during World War I, he pursued his education three years in Bethany College and one year in West Virginia University where he obtained his A. B. degree in 1922. He then married Miss Grace Campbell, of Peoria, Illinois, and spent the next four years teaching sciences in Point Marion High School, Pa., at the same time working towards a Master's Degree in chemistry.



H. T. PEASE, M. D.

In 1926, after his daughter Mary Lois was born, he entered Western Reserve University School of Medicine and received his M. D. degree in 1930, followed by an internship and residency in University Hospitals, Cleveland.

Dr. Pease opened his practice in Wadsworth, after a varied career which included diversified occupations from newsboy to lumberjack. He has practiced in Wadsworth since, with time out for postgraduate work at Harvard, the University of Michigan, University of Buffalo, and military service again during World War II. He was released from military duty in 1946, with the rank of Major after service as a combat surgeon with the Fifth Army.

Dr. Pease is an active member of the Medina County Medical Society having served as secretary-treasurer, president and almost perennial delegate. He is immediate past-chief of the Wadsworth Municipal Hospital staff, former member of the Hospital Board, associate member of the Summit County Medical Society, member of the American Academy of General Practice and has served many years on the State Association's Rural Health Committee. He is a member of Alpha Kappa Kappa, Phi Kappa Tau, Alpha Phi Epsilon (honorary literary) and Tau Kappa Alpha (honorary forensic).

He is a member of the Christian Church, past-president of Rotary Club, belongs to the Masonic Lodge, American Legion and Veterans of Foreign Wars.

PAST-PRESIDENT

Dr. Paul A. Davis, Akron, who handed the gavel to Dr. Prugh at the Annual Meeting, will

continue to serve on The Council for another year as immediate Past-President.

TREASURER

Dr. Richard L. Meiling, Columbus, has served two years of a three-year term as Treasurer.

COUNCILORS REELECTED

Councilors reelected for additional two-year terms are:

Dr. George A. Woodhouse, Pleasant Hill, was reelected Councilor of the Second District. He was elected in 1953 to serve the remaining year of the unexpired term of Dr. Prugh.

Dr. James R. Jarvis, Van Wert, was reelected Councilor of the Third District. He was elected to that office in 1952.

Dr. Charles L. Hudson, Cleveland, was reelected Councilor of the Fifth District. Dr. Hudson was first elected to that office in 1950 and reelected in 1952.

Dr. Carter L. Pitcher, Portsmouth, was reelected Councilor of the Ninth District. He was elected to that office in 1953 to serve the remaining year of the unexpired term of Dr. J. P. McAfee, who resigned.

Councilors in the midst of two-year terms are: Dr. Paul F. Orr, Perrysburg, Fourth District; Dr. C. A. Gustafson, Youngstown, Sixth District; Dr. Robert S. Martin, Zanesville, Eighth District; and Dr. Edwin H. Artman, Chillicothe, Tenth District.

Seek To Modernize and Improve State Laws Concerning Epileptics

Dr. Howard D. Fabing, of the University of Cincinnati College of Medicine, and Dean Roscoe L. Barrow, of the University of Cincinnati College of Law, recently reported findings of the legislative committee of the American League Against Epilepsy, to a joint scientific session of the League with the American Academy of Neurology, in Washington, D. C. Dr. Fabing is chairman of the legislative committee.

The Cincinnati university-prepared report presented an analysis of state laws and administrative practices affecting epileptics and asked this question: "What changes in laws and administrative practices affecting epileptics are justified by recent medical progress in the treatment of epilepsy?"

The report then proceeds to point out inconsistencies between legal provisions regarding epileptics and modern medical findings.

Next step in the League's project will be the drafting of model state laws on this subject and preparation of a medico-legal report in support of the recommended changes.

A meeting of the Cincinnati Medical Women's Club, Branch 11, was held on March 9 in the office of Dr. Edward Glaser, who gave a talk entitled "The Eyes Have It."

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since March 31, 1954. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ASHTABULA COUNTY
Konstantins Jakobsons, Dorset

BUTLER COUNTY
Joseph W. Hance, Hamilton

COLUMBIANA COUNTY
Robert N. Osmundsen, Salem

CUYAHOGA COUNTY
Richard A. Bloomfield, Cleveland
Henry M. Cryer, Cleveland
Charles J. Epstein, Cleveland
Arnold S. Gale, Cleveland
Laurence K. Groves, Cleveland
Edward A. Lundberg, Berea
Mieczyslaw Peszcynski, Cleveland

FRANKLIN COUNTY
James C. Good, Columbus
Maria Louise Madi, Columbus
Rex O. McMorris, Columbus
Robert T. Murnane, Columbus
Nellija Olga Rubenis, Columbus
William David Rummel, Columbus
Paul Arnold Saxon, Columbus
Edwin William Smelker, Columbus
Gwendolyn C. Trudeau, Columbus

HAMILTON COUNTY
John F. Cardosi, Cincinnati
Frank Clement, Cincinnati
Mary Clift, Cincinnati
Herbert C. Flessa, Cincinnati
Frank E. Von Holle, Cincinnati
Carl C. Luedeke, Cincinnati
Marvin J. Rassell, Cincinnati
Clayton R. Sikes, Jr., Cincinnati
William J. Stiles, Cincinnati
John W. Vester, Cincinnati
Isom C. Walker, Jr., Cincinnati
John J. Will, Mariemont
Carl Wisoff, Cincinnati
Emily E. Wright, Cincinnati

HANCOCK COUNTY
Raymond J. Tille, Jr., Findlay

LOGAN COUNTY
Alwin E. Schultz, Russels Point

LUCAS COUNTY
John J. Newton, Sylvania
Frank Vesey, Toledo
Robert L. Willard, Toledo

MAHONING COUNTY
James L. Finley, Petersburg
Edward G. Rizk, Youngstown
Alex M. Rosenblum, Jr., Youngstown

MIAMI COUNTY
H. Wayne Glotfelty, Piqua

MONTGOMERY COUNTY
James D. McCaffrey, Dayton

RICHLAND COUNTY
C. J. Shamess, Mansfield
Robert W. Tawse, Mansfield

ROSS COUNTY
Ernest Cutlip, Frankfort

STARK COUNTY
Paul C. Schwallie, North Canton

SUMMIT COUNTY
Max E. Griffin, Barberton
John Leland, Akron
Joseph B. Reilly, Akron

Dr. Arestad Takes United Mine Workers Fund Post

Dr. Fritjof H. Arestad, associate secretary of the A. M. A. Council on Medical Education and Hospitals, has resigned from his position to accept appointment with the Welfare and Retirement Fund of the United Mine Workers of America. Dr. Arestad will assume his new duties as medical administrator of the Johnstown, Pa., area on July 1.

He has been associated with the hospital work of the council since 1928, and during his 25 years of service he has been engaged in various activities related to the registration of hospitals, approval of internships and residencies, and the standardization of technical schools.

Annual Meeting in Review . . .

Here Are Brief Reports of Some of the Highlights and Sidelights That Contributed Toward a Successful Session in the Capital City

"ONE of the most satisfying meetings we've had," was an expression heard several times as members checked out of Columbus hotels following the 1954 Annual Meeting. The main events that made the meeting successful are reported in accompanying articles. Following are a few additional highlights and some sidelights that added much to that success.

GUEST SPEAKERS

The extensive program was conducted largely by picked Ohio physicians, but as in previous years, a number of guest speakers had been invited to fill key positions in the program.

To give all physicians an opportunity to hear the ten guest speakers, each presented a talk to a general session as well as appearing before a specialty group. Attendance ran high at these general sessions, filling the Grand Ballroom of the Neil House to capacity on occasions.

THE COUNCIL

The Council, in order to allow for the expanded program, met this year on Sunday evening preceding the Annual Meeting. It met the second time following the final meeting of the House of Delegates on Thursday. Minutes of these meetings will be found beginning on page 568.

Guests at this meeting were Past-Presidents of the Association, delegates to the A. M. A., key members of the Annual Meeting Committees and others. Of particular interest at this meeting was presentation of Past-President's Pins (see article and picture elsewhere in this issue).

THE HOUSE OF DELEGATES

The House of Delegates met first on Monday evening following dinner at the Neil House. The second meeting of the House was on Thursday morning following breakfast. In the interim, the various committees of the House met to prepare reports, hear discussions on resolutions, etc. Minutes of these meetings which establish policy of the Association will be found beginning on page 582.

Election of officers, a function of the House of Delegates, will be found in the official proceedings, while biographical sketches of the new officers and other information on members of The Council will be found beginning on page 572.

NEWS COVERAGE

The Public Relations Department provided information to all the Ohio newspapers several weeks prior to the meeting, giving them a roundup story of the program and listing for each newspaper the physicians in its area who were expected to participate in some way.

During the meeting, news was transmitted both day and night to the Columbus bureau offices of the Associated Press, United Press, International News Service, and the Columbus newspapers.

In addition, reporters covering the convention were given information at the press room, and members of the public relations staff conducted them to the various sessions and exhibits.

Speakers, officials and scientific exhibitors were located and introduced to the press representatives to facilitate the free flow of information to the public.

Out-of-town newspapers were represented by the following: *The Cleveland Press*, Don Dunham, Medical Editor; *The Toledo Blade*, Ray Bruner, science editor and Thomas P. Reynders; *The Dayton News*, Jerry Poston; *The Cleveland Plain Dealer*, Elizabeth Birkley.

Covering the meeting for Associated Press was Dick Brown; and for Scripps-Howard, Don Strouse.

In Columbus, *The Columbus Dispatch* was represented by Mary McGarey and Norman Dohn; *The Ohio State Journal* by Jack Elliott and Ed Barmann; and *The Columbus Citizen* by Doral Chenoweth and Gene Grove.

Dr. E. J. McCormick, President of the American Medical Association, was the guest of Mr. Dohn on the Globetrotter television news show at noon, April 13, on WBNS-TV; Columbus.

On the Friday following the meeting Chet Long, Columbus newscaster, presented a pictorial review of the meeting on his evening news program "Looking With Long," over WBNS-TV, Columbus.

THE BANQUET

The beautiful Grand Ballroom of the Neil House was an appropriate setting for the Banquet, where nearly 400 members, their wives and guests enjoyed the evening.

Special music was given in the form of vocal selections by the Men's Glee Club of Ohio State University, under direction of Professor Norman Staiger.

FOUR HONORED

Special event of the Banquet program was presentation of inscribed silver trays to four physicians who have distinguished themselves by their service to the medical profession and to the public.

Dr. J. H. J. Upham was honored "for his distinguished service to the medical profession



Some Camera Highlights of the Annual Meeting Program:

Top—Typical audience in the Grand Ballroom as a General Session program progresses.

Center—A panel of speakers puts on program for physicians —this one speaking on anesthesiology.

Right Inset—Dr. Judson Wilson, President of the Columbus Academy of Medicine, welcomes members of the House of Delegates in the name of the host society.

Left Inset—Outgoing President Paul A. Davis (right) relinquishes the gavel to Incoming President Merrill D. Prugh.

Bottom—Members of the House of Delegates proceed with business following breakfast on Thursday morning.

and the public, resulting from his devoted leadership in the affairs of his local, state and national medical societies and his outstanding contributions to medical education and medical licensure in the State of Ohio." Dr. Upham at the time of the meeting was in Florida where the tray was forwarded to him.

Dr. Edward J. McCormick was honored for "his distinguished services to the medical profession and the public, resulting from outstanding leadership given by him to his local, state and national medical societies."

Dr. H. M. Platter was honored for "his distinguished services to the medical profession and the public resulting from his devoted leadership in the activities of the Association and his outstanding record as administrative officer of the Medical Board of the State of Ohio."

Dr. Robert Conard was honored for "his distinguished services to the medical profession and the public, resulting from his efficient work as chairman of the Association's Military Committee and of the Ohio Advisory Committee to Selective Service and the Department of Defense during World War No. II and the Korean hostilities."

Presentations were made by President Paul A. Davis in behalf of the Association.

DR. McCORMICK IS HONOR GUEST

Dr. Edward J. McCormick, Ohio's own President of the American Medical Association, was honored guest for the occasion and delivered an inspiring talk as part of the Banquet program.

He reemphasized the positive program of the American Medical Association in contrast to criticism from outside the profession that the A. M. A. is "against" so many would-be progressive schemes. He expressed concern that the A. M. A. has been labeled as a negative body, reminding his hearers that representatives of the A. M. A. have spoken out in Washington against several legislative schemes with *thou shalt not*, but "never with a selfish motive."

Dr. McCormick pointed out that a large percentage of the income of the A. M. A. is expended in an effort to bring better medicine and health to the people—even though we have the best medical care in the world. He mentioned only a few of the many services being promoted by the profession—the medical education fund, voluntary medical and hospital insurance plans, rural health program with its efforts to interest more doctors in rural practice, the program for more equitable distribution of doctors between rural and metropolitan areas and between the military services and the civilian population.

Many Senators were surprised, he said, when informed what the A. M. A. is doing, particularly in such studies as that being conducted by the Council on Medical Economics in regard to indigent and medical indigent persons.

Contrary to the charge by those left of center that we in the medical profession are against all bills, Dr. McCormick said, the A. M. A. has opposed only those portions of bills that would destroy the principles that have made American medicine the most efficient that there is. "I defy those who oppose us to show where they have made contributions comparable to those of the medical profession," he challenged.

The speaker pointed out that while the A. M. A. is spending large amounts of money in services to the people, medical societies on the state and local levels are implementing those services to the public to an enormous amount.

Dr. McCormick concluded his talk with a challenge to doctors and their wives to carry on the tradition for private enterprise in medical practice and through private enterprise to preserve the American way of life.

OUT-OF-STATE GUESTS

In addition to the out-of-state guest speakers whose names appeared in the program, the Association was honored with representatives of neighboring state associations and other organizations. The list included: Mrs. Leo J. Schaefer, Salina, Kansas, President, Woman's Auxiliary to the A. M. A.; Dr. W. H. Howard, Hammond, Ind., President of the Indiana State Medical Association; Dr. Robert H. Baker, Pontiac, Mich., President-Elect of the Michigan State Medical Society and Mrs. Baker; Dr. James L. Whitehill, Rochester, Pa., President of the Medical Society of the State of Pennsylvania; Dr. W. L. Portteus, Franklin, Ind., President-Elect of the Indiana State Medical Association; Dr. Russel Kessel, Charleston, W. Va., President of the West Virginia State Medical Association, and Mrs. Kessel; and Dr. Robinson Joplin, Louisville, Ky., Vice-President of the Kentucky State Medical Association.

SCIENTIFIC EXHIBIT

One of the outstanding features of the meeting was the Scientific Exhibit in the Deshler-Hilton Hotel, which comprised 52 individual booths, each promoted in the interest of medical progress. Dr. George J. Hamwi, of Columbus, and his committee, did an outstanding job in arranging an excellent selection of exhibits and working with exhibitors during the meeting.

A committee was named to review the exhibits and to designate appropriate ones in point of excellence. The choice was as follows:

First place—The exhibit, "Diagnosis of Aorta-Iliac Artery Occlusion," sponsored by Drs. Fay A. LeFevre, Victor G. de Wolfe, A. W. Humphries, and J. C. Root, of the Cleveland Clinic.

Second Place—The exhibit entitled, "Diagnosis and Surgical Correction of Cardiac Lesions," sponsored by Drs. Charles V. Meckstroth, Karl P. Klassen, Joseph Ryan, of the Division of



Some Scenes at the Annual Banquet:

Top—The speakers' table, showing Officers, Councilors and guests.

Left Inset—Distinguished Guest Speaker, Dr. Edward J. McCormick, President of the American Medical Association.

Center—Dr. H. M. Platter, receives an inscribed silver tray from President Davis, a token of appreciation for his services to the profession. Similar gifts of appreciation were given to Dr. Robert Conard seated in the foreground, Dr. McCormick and, in absentia, to Dr. J. H. J. Upham.

Lower—One section of the Grand Ballroom showing some of the nearly 400 persons who enjoyed the Banquet.

Thoracic Surgery and Division of Cardiology, Ohio State University College of Medicine.

Third place—The exhibit, "Toxemias of Pregnancy Treated with Magnesium Sulfate," sponsored by Drs. J. A. Pritchard and A. C. Barnes, Department of Obstetrics and Gynecology, Western Reserve University School of Medicine.

Special organization award went to the Ohio Department of Health exhibit entitled, "Epidemiological Services to Ohio Physicians," arranged by Dr. John D. Porterfield, director of the Department, Dr. Fred Wentworth, chief of the Division of Communicable Diseases.

TECHNICAL EXHIBIT

A popular area during the meeting was the Mezzanine floor of the Neil House where physicians spent much time talking to detail men and women and gaining the latest information on pharmaceutical products and other supplies of the medical profession, displayed at the Technical Exhibit.

COMMITTEES DO EXCELLENT JOB

The House of Delegates made a point to put on its minutes a "thank you—well done" note to members of committees and others who cooperated to make the meeting successful.

The Committee on Scientific Work, which began plans last summer on the meeting, was composed of the following: Dr. A. Carlton Ernstene, Cleveland, chairman; Drs. William F. Ashe, Gallipolis; Louis G. Herrmann, Cincinnati; Thomas E. Rardin, Columbus; and Robert M. Zollinger, Columbus.

Local committees were headed by Dr. Earl H. Baxter, general chairman. Dr. O. F. Rosenow, was chairman of the Reception Committee, and Dr. Robert J. Murphy, chairman of the Committee on Halls and Meeting Places. Dr. George J. Hamwi was director of the Scientific and Educational Exhibits.

The Columbus Academy of Medicine furnished an emergency phone call service for physicians attending the meeting, the phones being manned by members of the Academy staff.

COUNTY OFFICERS, CHAIRMEN GET-TOGETHER

A feature of the meeting was the Conference of Officers and Public Relations Chairmen of County Medical Society, held Tuesday afternoon and evening with buffet supper in the Hall of Mirrors, Deshler-Hilton Hotel.

Subjects discussed were: "Why a Community Health Council?" "Grievance Committees—How They Work"; and "Making Public Relations Click."

WOMAN'S AUXILIARY

The Woman's Auxiliary to the Ohio State Medical Association held its Annual Meeting in the Southern Hotel concurrently with that of the Association. There was an excellent attendance of 327.

Mrs. A. Paul Hancuff, Toledo, assumed the presidency, succeeding Mrs. N. M. Reiff, Washington Court House, who serves among the officers for another year as immediate past-president.

Mrs. Karl Ritter, Lima, was named President-Elect. She was treasurer last year.

Other elected officers are: Mrs. Charles Obert, Cleveland, vice-president; Mrs. S. L. Meltzer, Portsmouth, recording secretary; Mrs. John Dickie, Toledo, corresponding secretary; Mrs. Herbert Van Epps, Dover, treasurer.

Ohio Medical Golfers To Meet at Mansfield

The 1954 annual tournament and get-together of the Ohio State Medical Golfers Association will be held at the Westbrook Country Club, Mansfield, on Thursday, June 10.

Physicians interested in participating should contact Mr. Robert W. Elwell, Academy of Medicine of Toledo headquarters, 3101 Collingwood Blvd., Toledo 10, who is secretary of the Golfers' Association.

Institute on Soil, Food and Health To Be Held in Chicago

The thirteenth annual Institue on Soil, Food and Health will be given by Friends of the Land at the Medical Center, University of Illinois, Chicago, Monday and Tuesday, June 28 and 29.

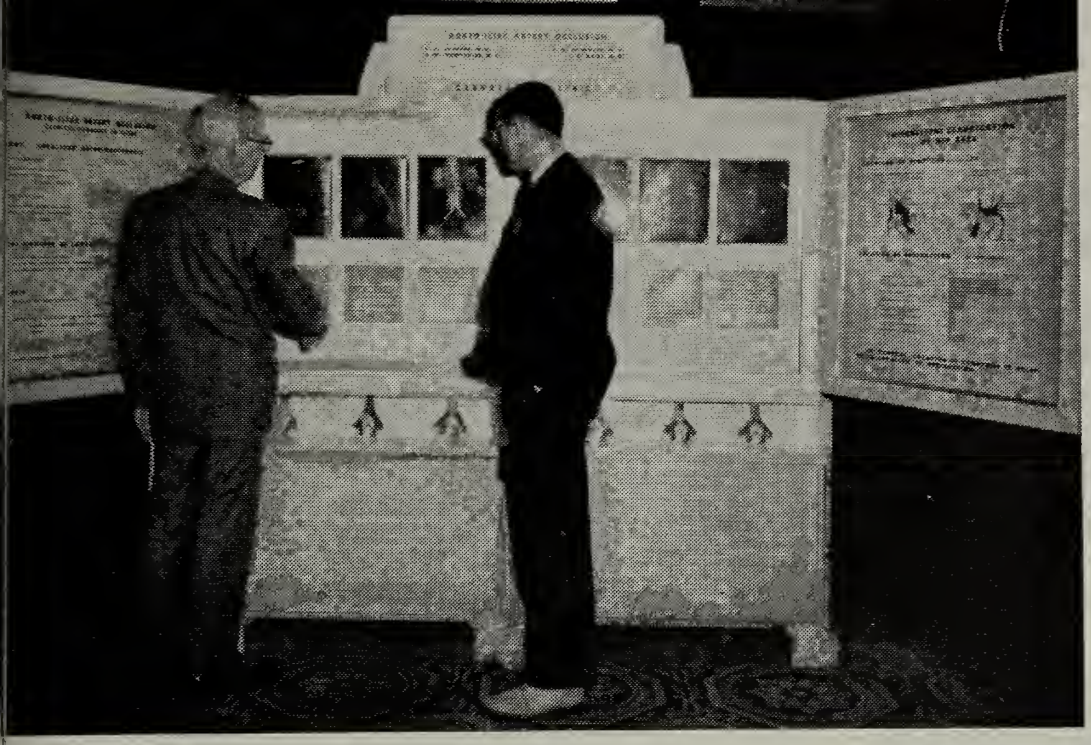
These institutes bring together from all over the nation 16 eminent scientists to make a popular summary of recent advances in their respective fields, in an effort to clarify the relationship of soil fertility to the health of plants and animals, and ultimately to the health of man himself.

In addition to the cooperation of the University of Illinois Medical College, the Chicago Medical Society and the Nutrition Committee of the Illinois State Medical Association have given their full support and cooperation to these programs since they have been moved to Chicago from Ohio.

Physicians and dentists are cordially invited to attend.

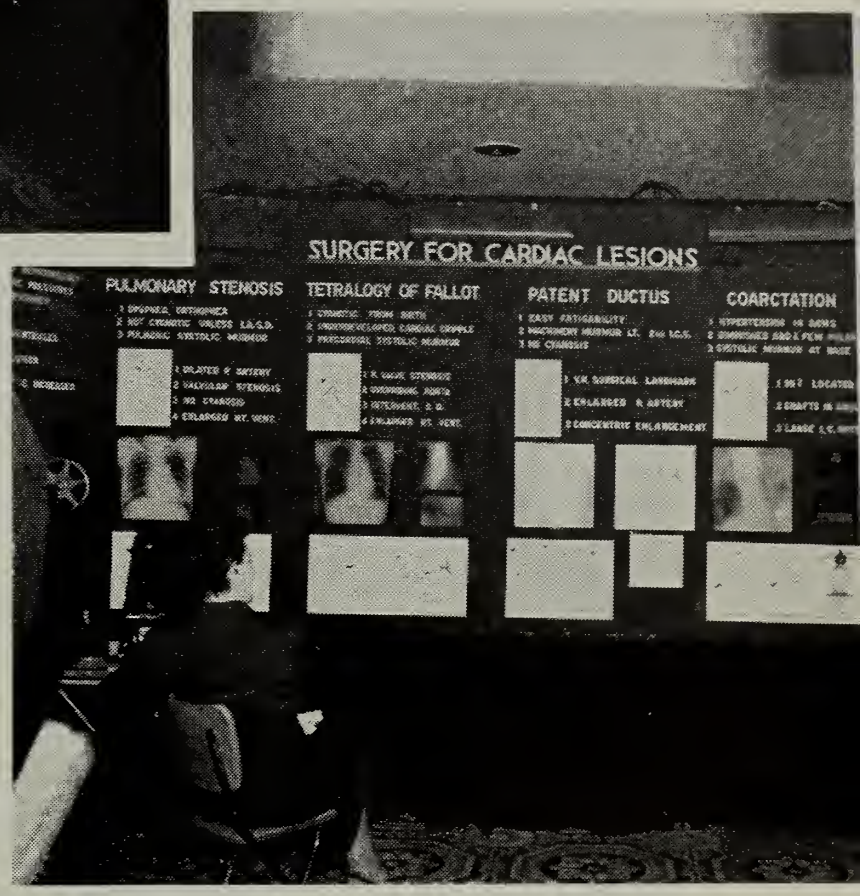
Postgraduate Gastroenterology

The National Gastroenterological Association has announced that its sixth annual course in postgraduate gastroenterology will be given at The Shoreham in Washington, D. C., and Walter Reed Army Hospital October 28-30. Further information may be had from the National Gastroenterological Association, Department GSJ, 33 West 60th Street, New York 23, N. Y.

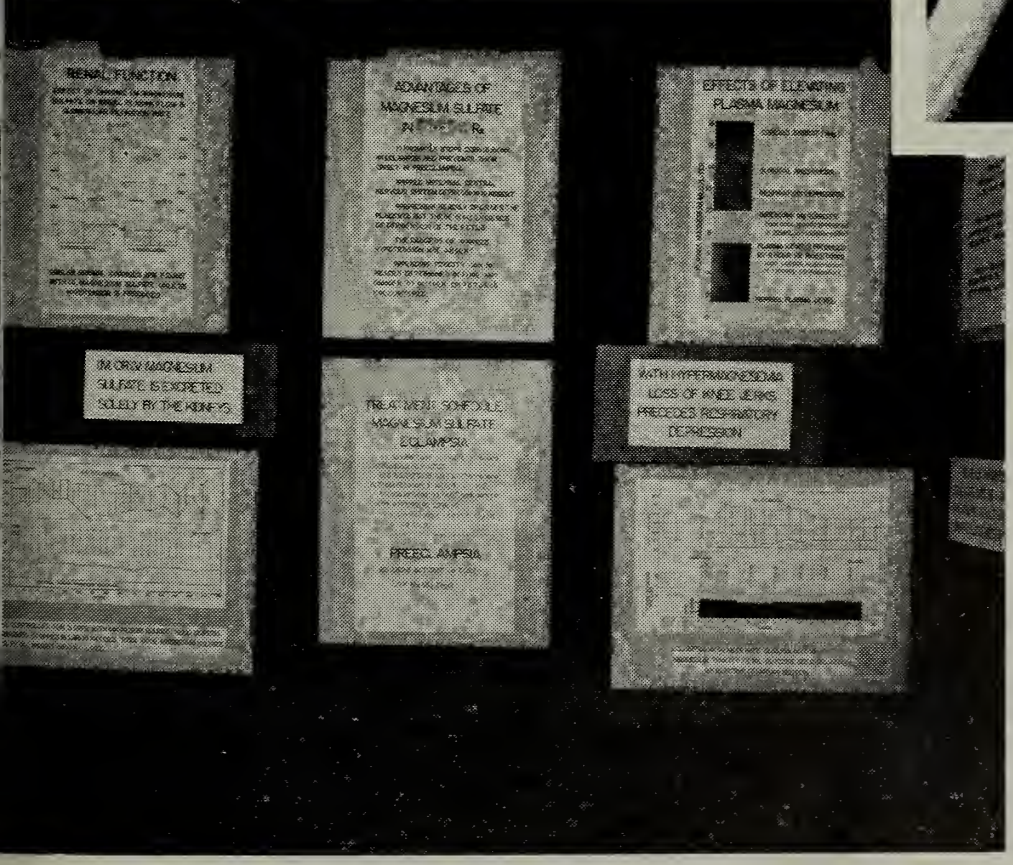


The Scientific Exhibit in the Desher-Hilton Hotel comprised 52 individual presentations, each an excellent educational feature in itself. On this page are photographs of exhibits named by a committee for their excellence.

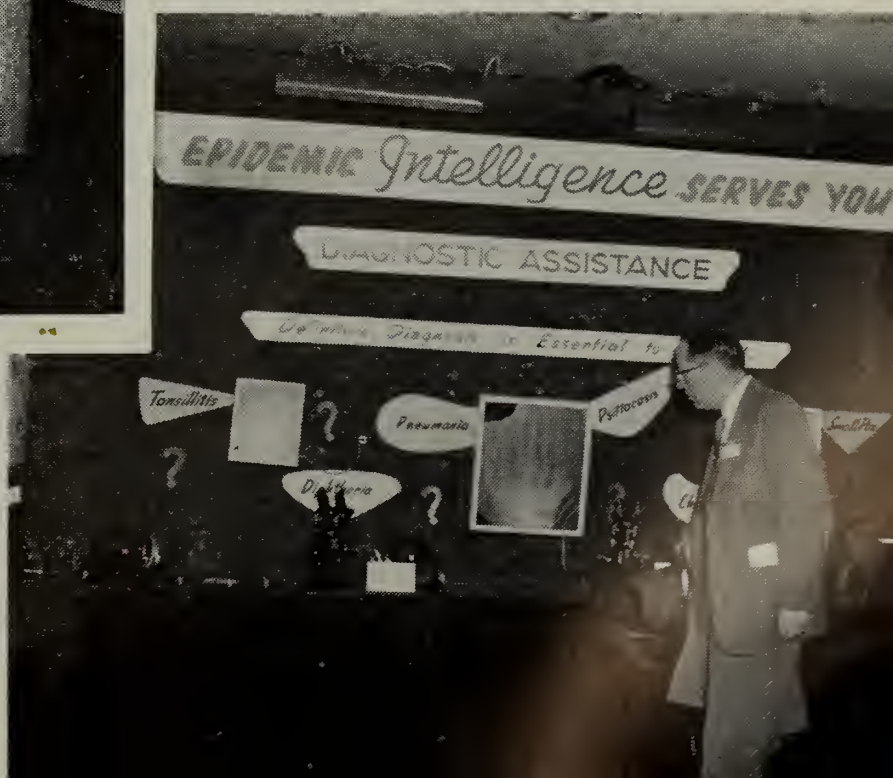
Above—First Place winner is the exhibit "Diagnosis of Aorta-Iliac Artery Occlusion," sponsored by Drs. Fay A. LeFevre, Victor G. de Wolfe, A. W. Humphries and J. C. Root, of the Cleveland Clinic.



Above—Second Place winner is the exhibit "Diagnosis and Surgical Correction of Cardiac Lesions," sponsored by Drs. Charles V. Meckstroth, Karl P. Klassen, Joseph Ryan, of the Division of Thoracic Surgery and Division of Cardiology, Ohio State University.



Above—Third Place winner, the exhibit entitled "Toxemias of Pregnancy Treated with Magnesium Sulfate," sponsored by Drs. J. A. Pritchard and A. C. Barnes, of the Department of Obstetrics and Gynecology, Western Reserve University.



Right—A special award for organizations and government agencies was given to this exhibit of the Ohio Department of Health, entitled "Epidemiological Services to Ohio Physicians."

House of Delegates . . .

Two Sessions Held During 1954 Annual Meeting, Columbus; Officers for Ensuing Year Elected; Seven Resolutions on Important Questions Adopted

MINUTES OF FIRST SESSION

THE first session of the House of Delegates of the 1954 Annual Meeting of the Ohio State Medical Association, April 12-15, was held in the Main Ballroom, Neil House, Columbus, Monday evening, April 12.

Following the dinner, the session was called to order by Dr. Judson D. Wilson, Columbus, President of the Columbus Academy of Medicine. Dr. Wilson extended a cordial welcome to all delegates and introduced the President of the Ohio State Medical Association, Dr. Paul A. Davis, Akron.

Dr. Davis then presented his presidential address. **(See pages 592-595 in this issue for Dr. Davis' address.)**

The House of Delegates then proceeded with scheduled business. On motion duly made, seconded and carried, the minutes of the meetings of the House of Delegates held during the 1953 Annual Meeting in Cincinnati were approved as published in *The Ohio State Medical Journal.*

GUESTS INTRODUCED

Dr. Davis then introduced Dr. Edward J. McCormick, Toledo, President of the American Medical Association and a Past-President of the Ohio State Medical Association, who responded with a few brief remarks. Dr. Davis also presented to the House of Delegates the following who were given an ovation by the delegates: Mr. Jack Devaney, representative of the Ohio State University College of Medicine Student A.M.A.; Mr. Hal Conwell, representative of the University of Cincinnati Student A.M.A.; Mr. Robert Ainsworth, representative of the Western Reserve University School of Medicine Student A.M.A.; Mr. Robert Smith, senior, Ohio State University College of Medicine, and winner of the second Ohio State Medical Association Rural Medical Scholarship.

Dr. Leonard Stack, Lorain, chairman of the Reference Committee on Credentials of Delegates, reported that 107 delegates and 15 officers and members of The Council, a total of 122, had qualified for participation in the proceedings.

REFERENCE COMMITTEES

President Davis then named the following reference committees:

Credentials of Delegates—Leonard Stack, Lorain, chairman; C. T. Atkinson, Middletown; Floyd M. Elliott, Ada; Edgar C. Pickard, Cuyahoga Falls.

President's Address—Carl C. Nohe, Akron, chairman; Robert C. Rothenberg, Cincinnati; D. J. Slosser, Defiance; Ralph W. Holmes, Chillicothe; E. J. Meckstroth, Sandusky.

Resolutions—E. K. Yantes, Wilmington, chairman; T. L. Light, Dayton; E. C. Brandt, Crestline; F. F. Rawling, Toledo; G. W. Petznick, Cleveland; John A. Fraser, East Liverpool; H. E. Reed, Dover; A. C. Ormond, Zanesville; G. N. Spears, Ironton; Charles W. Pavey, Columbus; N. P. Stauffer, Millersburg.

Tellers and Judges of Election—S. W. Ondash, Youngstown, chairman; J. L. Yahraus, Canton; Lowell Murphy, Cardington; M. D. Shilling, Ashland.

NOMINATING COMMITTEE CHOSEN

The next order of business was the nomination and election of a Nominating Committee as follows:

First District—Clifford G. Foor, Hillsboro, temporary chairman.
Second District—Ray M. Turner, Springfield.
Third District—R. F. Machamer, Tiffin.
Fourth District—George A. Boon, Oak Harbor.
Fifth District—H. A. Haller, Cleveland.
Sixth District—Wm. M. Skipp, Youngstown.
Seventh District—Carl F. Goll, Steubenville.
Eighth District—R. G. Plummer, Newark.
Ninth District—H. D. Chamberlain, McArthur.
Tenth District—R. W. Holmes, Chillicothe.
Eleventh District—John L. Jones, Medina.

RESOLUTIONS INTRODUCED

President Davis then called for the introduction of resolutions. Nine resolutions were presented and automatically referred to the Reference Committee on Resolutions. **(See minutes of Second Session for text of resolutions and action thereon.)**

Under new business the House of Delegates ratified the action of The Council approving the issuance to the Clark County Medical Society of a copy of its charter, the original having been lost.

The House then recessed until Thursday morning, April 15, for another business session.

MINUTES OF SECOND SESSION

The House of Delegates convened for the second and final session, Thursday morning, April 15, following a breakfast in the Town and Country Room, Neil House, Columbus.

Dr. Leonard Stack, Lorain, chairman of the Committee on Credentials, reported that 91 dele-

gates and 15 officers and members of The Council had submitted credentials; that such credentials had been approved; and that these delegates, officers and councilors had been seated.

President Davis introduced to the House of Delegates several guests. They were: Dr. James L. Whitehill, Rochester, Pennsylvania, President of the Medical Society of the State of Pennsylvania; Dr. W. H. Howard, Hammond, Indiana, President of the Indiana State Medical Association; Dr. W. L. Portteus, Franklin, Indiana, President-Elect of the Indiana State Medical Association; and Mr. James A. Waggener, Indianapolis, Indiana, Executive Secretary of the Indiana State Medical Society.

Reports of the Reference Committees were then called for by the President.

Dr. E. J. Meckstroth, Sandusky, reported for the Reference Commitee on President's Address, substituting for Dr. Carl C. Nohe, Akron, chairman of that committee, who had found it necessary to return to Akron because of an emergency.

The report of the committee, reading as follows, was approved on **motion** duly made, seconded and carried:

REPORT ON PRESIDENT'S ADDRESS

Your Committee has never believed in gilding the lily.

The President's address was so well thought out and so excellently delivered that it does not need any extensive review. It was superb because of its simplicity and modesty.

There are, however, two or three points in the address that are of such vital importance that your Committee feels they should be emphasized.

(1) The role of the individual doctor in public relations.

As Doctor Davis so forcefully said, "good public relations starts in each doctor's office and it is the duty of each and every doctor to be competent, and to be considerate, and friendly with each patient." We need not fear Socialized Medicine if our patients are 100 per cent for us.

(2) We wish to echo his statement of the excellence of the O.S.M.A. Columbus Office. "Chuck" Nelson and his staff are peerless. Your Committee believes it should be emphasized more and more to the doctors in Ohio what a host of services this office has prepared and is eager to give to practicing doctors.

(3) That we strive to develop closer cooperation between our County, State and National Societies.

Your Committee feels this is vital, for while the County Society is the foundation of medical activities, your Committee feels that too many doctors in Ohio lack interest in State and National Organizations. An intensive campaign of education is in order.

(4) We wish to pay our respects to the men who have worked long and faithfully on the Association's committees. What Dr. Davis has said concerning them meets with our heartiest approval.

Your Committee wishes to commend Doctor Davis not only for a job well done, but also for the kindly manner he used to accomplish it.

He came to us with a high love for our profession and a long training in organization work.

He is a tireless worker and has the great gift of making friends and keeping them.

He brought to the office a keen interest in the Practice of Medicine in all its phases.

He carried the torch high and guided his many strong committees to the attainment of many goals that will better Ohio Medicine.

Your Committee wishes to express appreciation to a distinguished and able gentleman for fine service and, on behalf of all the members of the Ohio State Medical Association, to wish him everything he wishes for himself in his future activities, and we earnestly hope he will still give us his inspiring leadership and advice in times of need.

On **motion** duly made, seconded and carried, the report was approved.

ACTION ON RESOLUTIONS

Dr. Davis then called on Dr. E. K. Yantes, Wilmington, chairman of the Reference Committee on Resolutions, to submit the report of that committee. The report of the committee read as follows:

Mr. President and members of the House of Delegates:

Nine resolutions were introduced at the first session of the House of Delegates and referred to the Reference Committee on Resolutions.

The committee met on Tuesday morning for the purpose of considering the resolutions and to hear testimony from authors, other delegates and members interested in the subjects covered by the resolutions.

RESOLUTION A

WHEREAS, Congressman Charles A. Wolverton on January 6, 1954 introduced HR-6949 which would establish a federal corporation to reinsure the voluntary non-profit health plans, and

WHEREAS, Congressman Charles A. Wolverton and Senator Alexander Smith introduced on March 11, 1954 HR-8356 and S-3114 (identical bills) which would establish a federal corporation to reinsure virtually every type of health plan, providing it is based on prepayment, and

WHEREAS, The voluntary plans of prepayment insurance have been enjoying a natural and healthy growth thus making it possible for more and more of the citizens to distribute the costs of their medical care through sound, actuarial insurance experience, and

WHEREAS, Financial assistance to the voluntary plans—either through federal reinsurance or federal subsidy—is not and should never be the responsibility of a centralized federal government, and

WHEREAS, Federal reinsurance would be a form of federal subsidization of the health plans, and

WHEREAS, Subsidization by any agent of government inevitably leads to control by government and to rapidly deteriorating performance of functions so subsidized, and

WHEREAS, Subsidy proposals represent merely an intermediate step by the socializers towards their ultimate goal of complete government domination, and

WHEREAS, Federal subsidy and control would materially weaken the voluntary plans by encouraging actuarially unsound insurance practices and thus make them a vehicle for complete socialization of medical care, and

WHEREAS, Financing of the provisions of the various proposals for subsidization of the voluntary prepayment insurance plans would require

millions of dollars which would have to be supplied through taxes from citizens already impoverished by existing needless and excessive taxation, and

WHEREAS, Federal financial assistance to the insurance plans would be an unfair and immoral act because it would constitute unfair competition to the insurance plans which refuse the federal aid.

THEREFORE BE IT RESOLVED, That the members of the Ohio State Medical Association, in regular session assembled this 15th day of April, 1954, do hereby go on record as opposing this legislation and any similar legislation and

BE IT FURTHER RESOLVED, That the members of the legislative committee and the officers of this Association should utilize every legitimate means to bring about the defeat of this legislation.

RESOLUTION C

WHEREAS, Congressman Charles A. Wolverton has introduced HR-6950, HR-6951 and HR-7700 to provide loans from Federal funds to voluntary non-profit health associations and voluntary prepayment health plans (similar to the Kaiser paneled doctors' system) and

WHEREAS, The program would be federally controlled and would discriminate against other groups, and

WHEREAS, Such loans can be had privately thereby eliminating this type of expensive federal subsidization, and

WHEREAS, Subsidization by any agent of government inevitably leads to control by government and to rapidly deteriorating performance of functions so subsidized, and

WHEREAS, Financial assistance to voluntary, non-profit health associations is not and should never be the responsibility of a centralized federal government.

THEREFORE BE IT RESOLVED, That the members of the Ohio State Medical Association in regular session assembled this 15th day of April 1954 do hereby go on record as opposing this legislation and any similar legislation and

BE IT FURTHER RESOLVED, That the members, the legislative committee and the officers of this Association should utilize every legitimate means to bring about the defeat of this legislation.

Resolution A and Resolution C, presented by Dr. Charles W. Pavey, Columbus, were considered jointly by the committee as both deal with related legislative proposals pending in the United States Congress.

After a thorough analysis of these questions, your committee drafted a substitute resolution covering the subject matters of Resolution A and Resolution C. The substitute resolution reads as follows:

> WHEREAS, One of the major objectives of the medical profession is to promote the best possible health care for all citizens and to assist them in working out sound methods of financing such care, and
>
> WHEREAS, Tremendous strides have been made through voluntary insurance plans and programs toward providing benefits to millions of Americans for meeting hospital, medical and surgical expenses, and
>
> WHEREAS, Voluntary insurance organizations and companies throughout the country, with the cooperation and assistance of the medical profession, are engaged in experiments and studies in the area of so-called catastrophic medical expense coverage with a view toward making more and better benefits available to all insurable persons, and
>
> WHEREAS, There is convincing evidence that the job of making health insurance coverage available to the maximum number of insurable persons can be done through voluntary insurance plans, and private initiative.
>
> THEREFORE, BE IT RESOLVED, That it is the opinion of the House of Delegates of the Ohio State Medical Association that there is no need for the enactment of legislation for government health insurance, including reinsurance, nor for legislation establishing a government agency or program for government loans or subsidies to voluntary insurance programs, or to prepaid plans or medical organizations, for facilities and equipment.
>
> AND BE IT FURTHER RESOLVED, That the members, officers and committees of the Ohio State Medical Association shall utilize every legitimate means to bring about the defeat of the following measures now pending in the United States Congress: H.R. 6949, H.R 8356, S. 3114, H.R. 6950, H.R. 6951 and H.R. 7700; and any similar bills which may be presented to the Congress.

Your committee recommends the adoption of the substitute resolution.

On **motion** duly made, seconded and **carried**, the recommendation of the committee, namely, that the substitute resolution for Resolutitons A and C be adopted, **was approved.**

RESOLUTION B

WHEREAS, The American Association of Physicians and Surgeons has for ten years sponsored an essay contest designed to familiarize high school students with the advantages of private medical care and

WHEREAS, This contest has grown until last year 19,000 package libraries were furnished to libraries and interested groups as source material for this contest and

WHEREAS, This contest has been a most important cog in the public relations machinery designed to sell the American people on private medical care and

WHEREAS, Recognition and endorsement of this contest by the O.S.M.A. would facilitate the work of the A.A.P.S. in getting county medical societies to sponsor and promote this contest

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association in convention assembled this 15th day of April 1954 go on record as endorsing the essay contest of the A.A.P.S. the essay title of which is "The Advantages of Private Medical Care."

Resolution B, introduced by Dr. Charles W. Pavey, Columbus, requests the Association to en-

Charting the Course Ahead



The camera caught this quick huddle at the close of the Annual Meeting, showing Immediate Past-President Davis, (left), President Prugh (center) and President-Elect Heusinkveld, discussing plans for carrying out the policy and program of the Association for the year.

dorse the 1954 essay contest of the American Association of Physicians and Surgeons.

Your committee has approved the resolution and recommends its adoptiton by the House of Delegates.

On **motion** duly made, seconded and **carried,** the recommendation of the committee, namely, that Resolution B be adopted, **was approved.**

RESOLUTION D

WHEREAS, Congressman Carl T. Curtis has introduced Social Security Bill HR-6863 and Congressman Daniel A. Reed has introduced Social Security Bill HR-7199 which would extend Social Security coverage to an additional 10,-500,000 persons, of which 6,500,000 persons, including physicians, would be compelled to join the system, and

WHEREAS, There is growing sentiment throughout the nation that the Social Security program is basically wrong and actuarially unsound and should be repealed, and

WHEREAS, The Social Security System is based on a complete compulsory principle that is contrary to the essential principles of individual liberty and freedom.

THEREFORE BE IT RESOLVED, That the members of the Ohio State Medical Association in regular session assembled this 15th day of April 1954 do hereby go on record as opposing this legislation and any similar legislation and

BE IT FURTHER RESOLVED, That the members, the legislative committee and the officers of this Association should utilize every legitimate means to bring about the defeat of this legislation.

Resolution D, also presented by Dr. Charles W. Pavey, Columbus, opposes the compulsory coverage of physicians in the Social Security System. Similar action was taken recently by The Council of the Association.

Your committee recommends that Resolution D **be amended by deleting the second and third paragraphs of the resolutiton and that the resolution, as amended, be adopted.**

On **motion** duly made, seconded and **carried,** the recommendation of the committee, namely, that Resolution D, as amended, be adopted, **was approved.**

RESOLUTION E

WHEREAS, The Joint Commission on Accreditation of Hospitals has stipulated the requirement of having at least 16 meetings per year for each hospital department (including 4 general staff meetings). Active staff attendance shall average at each meeting at least 75 per cent of the active staff. Each active staff member shall attend 75 per cent of staff meetings.

WHEREAS, In order to meet the stipulated meeting attendance requirement (aforementioned) many physicians would have to limit their active staff membership, thereby depriving the remaining hospitals of their active attendance, counsel and services.

WHEREAS, The strict enforcement of the attendance requirement will affect the smaller hospitals unfavorably by depleting their staff of competent men who will be forced to gravitate to larger hospitals.

WHEREAS, Multiple staff appointments promote professional unity in an area, prevent schisms and strengthen the County Medical Society.

WHEREAS, The strict enforcement of the hospital meeting attendance requirement will destroy

the effectiveness of the local County Medical Society, the basic unit of the American Medical Association.

WHEREAS, Investing authority for hospital meeting attendance and disciplinary action in a national body encourages assumption of authority by lay hospital boards in regulating staff meeting attendance to maintain accreditation.

THEREFORE, BE IT RESOLVED, That the hospital meeting attendance requirements be maintained by direct autonomy of each hospital, and

BE IT FURTHER RESOLVED, That disciplinary action on meeting attendance be the responsibility of the executive committee of the medical staff of the respective hospital.

Resolution E, introduced by Dr. Frank Rawling, Toledo, was given prolonged study by the committee and was discussed by many attending the committee meeting.

In order to strengthen the resolution and clarify some of its wording, the committee **recommends that the following be substituted for the last two paragraphs of the resolution and recommends the adoption of the resolution, as amended:**

"THEREFORE, BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association instruct the Association's delegates to the American Medical Association to introduce a resolution at the June session of the A.M.A., requesting the Joint Commission on Accreditation of Hospitals to take the following actions:

"(1) That the Commission repeal the existing requirement concerning attendance at hospital staff meetings;

"(2) That the Commission omit entirely from its regulations any requirement for staff meeting attendance as a part of the hospital accreditation procedure;

"(3) That the Commission adopt the policy that the matter of attendance at staff meetings be left to the autonomy of the medical staff of the individual hospital."

On **motion** duly made, seconded and **carried**, the recommendation of the committee, namely, that Resolution E, as amended, be adopted, **was approved.**

RESOLUTION F

WHEREAS, The narcotics problem is a growing menace to the health and welfare of our citizens, and

WHEREAS, The 100th Ohio General Assembly, by the enactment of Senate Bill 33, authorized Attorney General C. William O'Neill, with the assistance of other governmental and private agencies, to make a comprehensive study of existing laws relating to the control of narcotics and their use; to evaluate present law enforcement, penal and rehabilitative procedures and their adequacy; and to make recommendations for such changes in law and procedures as may be necessary to insure adequate control of narcotics and their use, and

WHEREAS, The Attorney General has indicated that he expects to appoint a Citizens Advisory Committee on Narcotics in each county in the state and a State Advisory Committee composed of representatives of the county Committees, and

WHEREAS, The Attorney General plans to have these committees study the results of his investigation, evaluate and discuss the problem and to advise him in the drafting of legislation that may be necessary to cope with the illegal use of narcotics in Ohio, and

WHEREAS, Officials of the Ohio State Medical Association are cooperating with the Attorney General in the conduct of this investigation.

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association, in session April 12-15, 1954, in Columbus, Ohio, strongly urges that all county medical societies and their members cooperate fully in the Ohio Narcotics Investigation, and join with other citizens in this commendable attempt of the Ohio General Assembly and the Attorney General to solve this serious problem.

Resolution F, dealing with the narcotics problem, was introduced by Dr. T. L. Light, Dayton.

Your committee endorses this resolution and recommends its adoption.

On **motion** duly made, seconded and **carried**, the recommendation of the committee, namely, that Resolution F be adopted, **was approved.**

RESOLUTION G

"WHEREAS, there are certain cases of hardship wherein there is at present no provision for remission of dues and assessments, and

"WHEREAS, there is no uniformity in regard to hardship cases between American Medical Association and Ohio State Medical Association,

"BE IT RESOLVED, that the By-Laws of the Ohio State Medical Association be amended in the following particulars:

"1. The second (2nd) paragraph of Chapter I, Section 4 of the By-Laws reading:

"'Provided, however, that a doctor of medicine who is not engaged in active practice because of age or disability and who was a member in good standing of this Association at the time of his retirement from active practice shall be exempt from the payment of dues and assessments in this Association, providing he requests such exemption and such request is approved in writing by the secretary-treasurer of his component society. Provided, further, that The Council of this Association shall have the authority to promulgate regulations providing for the waiver of dues and assessments for members entering active military service on a temporary basis in times of national emergency,' be repealed.

"2. There be added to Chapter I, Section 4 of the By-Laws, the following:

"The Council of this Association shall have the authority to excuse the following members from payment of dues and assessments:

"(a) A member for whom the payment of dues would be a financial hardship by reason of physical disability or illness.

"(b) A member for whom payment of dues would be a financial hardship for reasons other than those set forth in the preceding paragraph (a), provided such fact be affirmed by the Secretary of the Member's component Society.

"(c) A member not engaged in active practice because of age or disability, provided such member was in good standing in this Association at the time of his retirement from active practice and provided such member requests such exemption in writing and such request be

approved in writing by the Secretary-Treasurer of his component Society.

"(d) Members entering active Military Service on a temporary basis.

"The Council of this Association shall have authority to promulgate regulations governing the remission of dues and assessments of members under the foregoing categories."

Resolution G, introduced by Dr. Edgar C. Pickard, Akron, recommends a change in the By-Laws of the Association. It proposes the waiver of state dues for members claiming financial hardship.

The present By-Laws provide waiver of state dues for members who are not engaged in active practice because of age or disability and for members in active military service on a temporary basis.

It is the opinion of your committee that the present By-Laws are entirely adequate to meet justifiable cases where members should not be assessed state dues. Also, it feels that the proposed expansion of the waiver of dues policy would create serious administrative problems.

Therefore, your committee recommends that Resolution G **not be adopted.**

On **motion** duly made, seconded and carried, the recommendation of the committee, namely, that Resolution G not be adopted, **was approved.**

RESOLUTION H

WHEREAS, The provision of adequate public health facilities for the people of Ohio is primarily a state and local responsibility, and

WHEREAS, The Ohio Department of Health for many years received as high as 70 per cent of its operating funds from the Federal Government, and

WHEREAS, The 100th Ohio General Assembly last year recognized and established the basic principle that it is the responsibility of the state to carry the major financial requirements of this department, and

WHEREAS, The 100th Ohio General Assembly appropriated a total of $2,637,558 for the use of the department for the fiscal year 1954-1955 as compared with $1,751,828 appropriated during the previous biennium for central office operations for carrying out the provisions of the Ohio public health laws, and

WHEREAS, For the first time in many years the department is receiving a majority of its funds from the state instead of from the Federal Government, and

WHEREAS, The Ohio Department of Health, under the able leadership of Dr. John D. Porterfield, State Director of Health, is doing an outstanding job for the people of Ohio,

BE IT RESOLVED:

1. That the House of Delegates of the Ohio State Medical Association in session, April 12-15, in Columbus, Ohio, congratulates and commends the leadership and membership of the 100th General Assembly for courageously and realistically facing this important issue, instead of relying on Federal handouts,

2. That the House of Delegates also expresses its appreciation to Dr. Porterfield and his staff for their efficient efforts to improve public health facilities in the State of Ohio.

Resolution H was introduced by Dr. Wm. M. Skipp, Youngstown.

Your committee approves the resolution and recommends its adoption.

On **motion** duly made, seconded and carried, the recommendation of the committee, namely, that Resolution H be adopted, **was approved.**

RESOLUTION I

WHEREAS, The greatest number of casualties during the Second World War were in the neuro-psychiatric field, and

WHEREAS, The expansion of Veterans Administration beds since 1945 has been predominantly of general medical and surgical beds, and

WHEREAS, The recognized national need is for neuro-psychiatric beds for veterans, and

WHEREAS, There are now more than 1600 veterans in state mental institutions in Ohio, and

WHEREAS, There are over 300 veteran mental patients in over-crowded Longview State Hospital in Cincinnati, and

WHEREAS, There now is a surplus of some 400 general medical and surgical beds in the Dayton Veterans Administration Hospital, and

WHEREAS, There has not been a serious waiting list for these beds for veterans for some years, and

WHEREAS, The vast majority of general medical and surgical cases treated at the Dayton Veterans Hospital have been treated for non-service connected disease and

WHEREAS, The Veterans Administration is preparing to open some 350 more unnecessary general medical and surgical beds in the Cincinnati Veterans Hospital, and

WHEREAS, Cincinnati is an area of acute community bed and nursing shortage and the opening of these beds will result in a useless drain on vital community health personnel,

NOW THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association recommends a careful study of the entire problem of Veterans Administration Hospital policies in the Cincinnati-Dayton area, and

BE IT FURTHER RESOLVED, That all Veterans in State mental institutions be carefully surveyed as to the service connection of their illness, and that the service-connected patients be transferred to Veterans Administration hospitals if they so desire, as soon as possible, and

BE IT FURTHER RESOLVED, That eligible non-service connected veteran medic patients now in State Mental Institutions, be given priority for a Veterans Administration Hospital Bed over non-service connected veteran patients hospitalized for acute diseases of relatively short duration.

Resolution I, introduced by Dr. Foster M. Williams, Cincinnati, deals with the Veterans Administration hospital building program and the policies of the Veterans Administration pertaining to the operation of its hospitals.

In order to clarify the intent of the resolution, your committee recommends **that the resolution be amended by substituting the following for the last three paragraphs and that the resolution, as amended, be adopted:**

"NOW THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association instruct the Committee on Medical Care of Veterans as follows:

"(1) That the committee study Veterans

Administration hospital policies as they apply to the entire State of Ohio and report its findings and recommendations to The Council at the earliest possible time;

"(2) That the committee endeavor to arrange for a survey of all veterans in Ohio's mental institutions for the purpose of determining whether or not their illness is service-connected and recommend to the proper state officials and officials of the Veterans Administration that veterans with service-connected ailments be transferred as soon as possible to Veterans Administration hospitals, if such veterans desire transfer.

"(3) Although the Ohio Medical Association believes that the law pertaining to the care of veterans should be modified to exclude care for veterans with non-service-connected disabilities, so long as the present law is in effect a policy should be established whereby veterans with non-service-connected mental diseases who are now in a state mental institution and who desire admission to a Veterans Administration hospital, will be given priority over veterans with non-service-connected diseases and disabilities of relatively short duration. This recommendation should be transmitted immediately to the proper Veterans Administration officials who should be urged to establish the policy recommended at the earliest possible date."

Your committee recommends the adoption of Resolution I, as amended.

On **motion** duly made, seconded and **carried**, the recommendation of the committee, namely, that Resolution I, as amended, be adopted, **was approved.**

Dr. Yantes then moved that the report of the Reference Committee, as amended, be approved. The motion was seconded and carried.

Dr. Yantes then expressed appreciation to the following members of his committee for the fine work which they had done and for having devoted so much time to the resolutions considered: Dr. T. L. Light, Dayton; Dr. E. C. Brandt, Crestline; Dr. F. F. Rawling, Toledo; Dr. G. W. Petznick, Cleveland; Dr. John A. Fraser, East Liverpool; Dr. H. E. Reed, Dover; Dr. A. C. Ormond, Zanesville; Dr. G. N. Spears, Ironton; Dr. Charles W. Pavey, Columbus; and Dr. N. P. Stauffer, Millersburg.

ELECTION OF PRESIDENT-ELECT

The President then called for nominations from the floor for the office of president-elect.

Dr. Robert C. Rothenberg, Cincinnati, placed in nomination the name of Dr. David W. Heusinkveld, Cincinnati, a member of The Council from the First District. The nomination was seconded by Dr. E. K. Yantes, Wilmington.

There being no further nominations, on **motion** duly made, seconded and unanimously **carried**, the nominations were closed and Dr. Heusinkveld was elected president-elect by acclamation.

At the request of the President, Dr. Rothenberg and Dr. Yantes escorted Dr. Heusinkveld to the rostrum. Dr. Heusinkveld was given an ovation and he addressed the House of Delegates briefly.

During the course of his remarks, Dr. Heusinkveld quoted the following—"Eulogy of the Doctor" by Robert Louis Stevenson—expressing the hope that members of the profession would strive to measure up to the sentiments expressed therein:

"There are men and classes of men that stand above the common herd—the soldier, the sailor, the shepherd not infrequently, the artist rarely, rarelier still the clergyman, the physician almost as a rule. He is the flower of our civilization and when that stage of man is done with, only to be marvelled at in history, he will be thought to have shared but little in the defects of the period and to have most notably exhibited the virtues of the race. Generosity he has, such as is possible only to those who practice an art and never to those who drive a trade: discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage. So it is that he brings air and cheer into the sick room and often enough, though not so often as he desires, brings healing."

In concluding his informal comments, Dr. Heusinkveld read the following "Physician's Prayer":

PHYSICIAN'S PRAYER

"Lord, Who on earth didst minister
To those who helpless lay
In pain and weakness, hear me now,
As unto Thee I pray.
Give to mine eyes the power to see
The hidden source of ill,
Give to my hand the healing touch,
The throb of pain to still.
Grant that mine ears be swift to hear
The cry of those in pain;
Give to my tongue the words that bring
Comfort and strength again.
Fill Thou my heart with tenderness,
My brain with wisdom true,
And when in weariness I sink,
Strengthen Thou me anew.
So in Thy footsteps may I tread,
Strong in Thy strength always,
So may I do Thy blessed work
And praise Thee day by day."

ELECTION OF COUNCILORS

Dr. Clifford G. Foor, Hillsboro, chairman of the Committee on Nominations, then submitted the following report on behalf of that committee:

FIRST DISTRICT

The committee placed in nomination the name of Dr. David W. Heusinkveld, Cincinnati, to succeed himself as Councilor for the First District.

The President ruled that the nomination was not in order, inasmuch as Dr. Heusinkveld had just been nominated and elected as president-elect, and he called for nominations from the floor. The name of Dr. Charles T. Atkinson, Middletown, was placed in nomination for the office of Councilor for the First District and the nomination was duly seconded. There being no further nominations, on **motion** duly made, seconded and **carried**, the nominations were closed and Dr. Atkinson was elected Councilor of the First District, by acclamation, for the years 1954 and 1955.

THIRD DISTRICT

As Councilor for the Third District the committee placed in nomination the name of Dr. J. R. Jarvis, Van Wert, to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded, and **carried**, Dr. Jarvis was elected Councilor of the Third District, by acclamation, for the years 1954 and 1955.

FIFTH DISTRICT

As Councilor for the Fifth District, the committee placed in nomination the name of Dr. Charles L. Hudson, Cleveland, to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried**, Dr. Hudson was elected Councilor of the Fifth District, by acclamation, for the years 1954 and 1955.

SEVENTH DISTRICT

As Councilor for the Seventh District, the committee placed in nomination the name of Dr. Robert Hopkins, Coshocton, to succeed Dr. R. J. Foster, New Philadelphia, who had completed three consecutive terms on The Council and under the Constitution and By-Laws was ineligible for renomination and re-election. There being no further nominations, on **motion** duly made, seconded and **carried**, Dr. Hopkins was elected Councilor of the Seventh District, by acclamation, for the years 1954 and 1955.

NINTH DISTRICT

As Councilor for the Ninth District, the committee placed in nomination the name of Dr. C. L. Pitcher, Portsmouth, to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and **carried**, Dr. Pitcher was elected Councilor of the Ninth District, by acclamation, for the years 1954 and 1955.

ELEVENTH DISTRICT

As Councilor of the Eleventh District, the committee placed in nomination the name of Dr. H. T. Pease, Wadsworth, to succeed Dr. John S. Hattery, Mansfield, who had completed three consecutive terms on The Council and who, under the Constitution and By-Laws, was ineligible for renomination and re-election. There being no further nominations, on **motion** duly made, seconded and **carried**, Dr. Pease was elected Councilor of the Eleventh District, by acclamation for the years 1954 and 1955.

Advance Registration for A. M. A. Meeting

To avoid the crowds, physicians already in the San Francisco area may register in advance on Sunday, June 20, for the American Medical Association's 103rd Annual Meeting. Registration facilities will be open on that day from 10 a. m. to 4 p. m. in the portico entrance to the Civic Auditorium at Civic Center where both the Technical and Scientific Exhibits will be held. All A. M. A. members should bring along pocket membership cards for admittance.

At this point President Davis interrupted the reading of the report of the Committee on Nominations. He asked Dr. Foster and Dr. Hattery to stand and be recognized. They did so. Dr. Davis then congratulated them for the fine job which they had done as Councilors and expressed officially the sincere appreciation of the Association for their earnest and untiring efforts. Dr. Foster and Dr. Hattery were given a big ovation by the House of Delegates.

A.M.A. DELEGATES ELECTED

The committee then presented the following nominations for the office of delegate and alternate to the American Medical Association to be filled at this year's meeting, such delegates and alternates to start their terms January 1, 1955, and to serve for two years, namely, the calendar years 1955 and 1956.

Dr. Carl A. Lincke, Carrollton, delegate, and Dr. H. M. Platter, Columbus, alternate.

Dr. Wm. M. Skipp, Youngstown, delegate, and Dr. C. E. Hufford, Toledo, alternate.

Dr. George A. Woodhouse, Pleasant Hill, delegate, and Dr. R. Dean Dooley, Dayton, alternate.

Dr. Herbert B. Wright, Cleveland, delegate, and Dr. Fred W. Dixon, Cleveland, alternate.

There being no further nominations, on **motion** duly made, seconded and **carried**, the nominations were closed and the foregoing nominees were elected, by acclamation, for two-year terms starting January 1, 1955.

DR. PRUGH INSTALLED

President Davis then turned over the official gavel to Dr. Merrill D. Prugh, Dayton, and officially installed him as President of the Association.

In accepting the gavel, Dr. Prugh then presented to Dr. Davis a Past-President's gold lapel emblem and warmly congratulated him for a very successful term of office. Dr. Prugh then addressed the House of Delegates as follows:

"Last year I told you how much I appreciated

the honor and how keenly aware I was of the responsibilities of the presidency of the Ohio State Medical Association. Now has come the time for the responsibility, and it is great. I have no hesitancy in assuming that responsibility because with your help, as a united profession in Ohio, nothing is impossible. We have many problems, as yet unsolved. I shall mention only a few of these:

"1. Medical care of veterans and their dependents.
"2. A continuous legislative program.
"3. The various health activities on a statewide level.
"4. The narcotics control problem.
"5. Numerous hospital problems, including the new system of accreditation.

"I am going to call your attention to a few simple facts which I am sure every member of the Association knows as well as I, but which must be kept before us as a definite objective.

"Any medical organization, to justify its existence must:

"1. Serve the patient and the public.
"2. Serve the doctor and the profession.

"The county medical society is the whole basis of our united effort as organized medicine. We must make our county medical societies strong for that will determine whether we succeed or fail.

"To be strong, county societies must:

"1. Have a definite program of activities as broad as the size and the personnel of the group will permit.
"2. Have programs, business and professional, of the broadest possible interest, in order to increase the interest and attendance of the members.
"3. Get the younger men actively working in county society affairs.
"4. Actively participate in all community activities pertaining to health and civic affairs.
"5. Stress the ideals of medicine and if necessary, discipline willful offenders.

"As individual members, we must:

"1. Give good medical service.
"2. Make our service available at all times for all who need it.
"3. Make our fees fair to both the patient and the doctor.
"4. Make our personal interest in the patient, known to the patient. A few extra minutes spent with each patient will give surprising results.
"5. Cooperate with our fellow practitioners and avoid disparging acts or remarks. In short, help one another; because any other course harms only the one who attempts to belittle his fellow practitioner.
"6. Keep our hands clean.

"These 'musts' are nothing new. In fact they are old, but so is the best rule of human conduct ever given, namely: The Golden Rule, and in 2000 years, no one has been able to give us a better rule.

"If we will do these few simple things, public relations will be no unsolved problem and socialized medicine no threat. We will have the respect of the public and best of all, our own self respect.

"I pledge you that I shall do everything in my power to advance the standards and objectives of the Ohio State Medical Association which are in effect, the standards and objectives of the medical profession."

At the conclusion of his remarks Dr. Prugh also sincerely thanked Dr. Foster and Dr. Hattery for their fine job as Councilors.

The following committee appointments were presented to the House of Delegates by President Prugh and were confirmed on motion duly made, seconded and carried.

COMMITTEES APPOINTED

Committee on Education—Dr. Ian B. Hamilton, Canton, for a term of five years. Dr. Carl A. Wilzbach, Cincinnati, a member of the committee, to serve as chairman for the ensuing year.

Judicial and Professional Relations Committee—Dr. R. Dean Dooley, Dayton, for a term of five years. Dr. E. J. Wenaas, Youngstown, a member of the committee, to serve as chairman for the ensuing year.

Committee on Public Relations and Economics—Dr. Frederick P. Osgood, Toledo, for a term of five years. Dr. Herbert B. Wright, Cleveland, a member of the committee, to serve as chairman for the ensuing year.

Committee on Scientific Work—Dr. A. Carlton Ernstene, Cleveland, for a term of five years, and to serve as chairman for the ensuing year.

NEW BUSINESS

Under the order of new business Dr. Ralph W. Holmes, Chillicothe, presented a motion extending sincere appreciation and thanks to the Committee on Scientific Work; Dr. George J. Hamwi, Columbus, Director of the Scientific and Educational Exhibit; all committees of the Columbus Academy of Medicine; members of the office staff of the Columbus Academy of Medicine; officials of the Neil House and Deshler-Hilton Hotels; representatives of Columbus newspapers, radio and television stations, as well as to all program participants and others who had a part in making the Columbus meeting so successful. Dr. Holmes' motion was adopted by a standing vote.

There being no further business, the House of Delegates adjourned sine die.

Attest: CHARLES S. NELSON
Executive Secretary

HOUSE OF DELEGATES
ROLL CALL — 1954 MEETING

County	Delegate	First Session	Second Session
	FIRST DISTRICT		
ADAMS	S. J. Ellison	Present	Present
BROWN			
BUTLER	William U. Neel	Present	Present
CLERMONT			
CLINTON	E. K. Yantes	Present	Present
HAMILTON	Charles D. Bahl	Present	----------
	Richard D. Bryant	Present	----------
	Joseph G. Crotty	Present	----------
	Harry K. Hines	----------	Present
	J. Robert Hudson	----------	Present
	E. S. Lotspeich	----------	Present
	Elmer Maurer	Present	Present
	John H. Payne	Present	----------
	Robert C. Rothenberg	Present	Present
	Foster M. Williams	Present	Present
	Robert M. Woolford	Present	Present
HIGHLAND	Clifford G. Foor	Present	Present
WARREN			
	SECOND DISTRICT		
CHAMPAIGN	I. Miller	Present	Present
CLARK	J. H. Shanklin	----------	Present
	Ray M. Turner	Present	Present
DARKE	Maurice Kane	Present	Present
GREENE	Paul D. Espey	Present	Present
MIAMI	Dale A. Hudson	Present	Present
MONTGOMERY	Lynne E. Baker	----------	Present
	H. J. Bearzy	----------	Present
	A. W. Carley	Present	Present
	R. C. Doan	Present	Present
	R. Dean Dooley	Present	Present
	H. M. James	Present	----------
	T. L. Light	Present	----------
PREBLE	E. P. Trittschuh	Present	----------
SHELBY			
	THIRD DISTRICT		
ALLEN	Edward B. Young	Present	Present
	Carl H. Zinsmeister	----------	Present
AUGLAIZE			
CRAWFORD			
HANCOCK	Frank M. Wiseley	Present	----------
HARDIN	Floyd M. Elliott	Present	----------
LOGAN	H. L. Mikesell	Present	Present
MARION			
MERCER	Julius Schwieger	Present	----------
SENECA	R. F. Machamer	Present	Present
VAN WERT	H. D. Underwood	Present	Present
WYANDOT	F. M. Smith	Present	Present
	FOURTH DISTRICT		
DEFIANCE	D. J. Slosser	Present	----------
FULTON	C. S. Kellogg	Present	Present
HENRY			
LUCAS	Crawford L. Felker	Present	Present
	C. R. Forrester	Present	Present
	David C. Frick	Present	Present
	J. L. Kobacker	Present	----------
	Frank F. A. Rawling	Present	Present
OTTAWA	George A. Boon	Present	Present
PAULDING			
PUTNAM			
SANDUSKY			
WILLIAMS	J. R. Riesen	----------	Present
WOOD	F. F. Price	Present	----------
	FIFTH DISTRICT		
ASHTABULA			
CUYAHOGA	F. L. Browning	Present	Present
	John H. Budd	Present	----------
	Wm. J. Engel	Present	Present
	H. A. Haller	Present	Present
	John B. Hazard	Present	Present
	Stanley Hoerr	Present	----------
	C. R. Jablonski	Present	Present
	F. R. Kelly	Present	Present
	F. A. LeFevre	----------	Present
	C. R. Lulenski	Present	Present
	John W. Martin	Present	Present
	Paul A. Mielcarek	----------	Present
	Paul G. Moore	----------	Present
	George W. Petznick	Present	Present
	H. W. Salter	Present	Present
	B. B. Sankey	----------	Present
	Edward W. Shannon	Present	----------
	Thomas A. Shehan	Present	Present
	Keith W. Sheldon		Present
	G. A. Tischler	Present	----------
	R. J. Whitacre	Present	Present
GEAUGA	Alton W. Behm	Present	----------
LAKE	Morris G. Carmody	Present	----------

County	Delegate	First Session	Second Session
	SIXTH DISTRICT		
COLUMBIANA	John A. Fraser	Present	Present
MAHONING	M. W. Neidus	Present	Present
	S. W. Ondash	Present	Present
	Wm. M. Skipp	Present	Present
PORTAGE	Myron W. Thomas	Present	Present
STARK	Lloyd L. Dowell	Present	Present
	J. L. Yahraus	Present	Present
	G. D. Underwood	Present	----------
SUMMIT	A. W. Friend	Present	Present
	Donald I. Minnig	Present	Present
	Carl C. Nohe	Present	----------
	E. C. Pickard	Present	Present
TRUMBULL	A. L. Williamson	Present	----------
	SEVENTH DISTRICT		
BELMONT	Peter Lancione	Present	----------
CARROLL	T. J. Atchison	Present	----------
COSHOCTON	W. R. Agricola	Present	Present
HARRISON			
JEFFERSON	C. F. Goll	Present	----------
MONROE			
TUSCARAWAS	H. E. Reed	Present	Present
	EIGHTH DISTRICT		
ATHENS			
FAIRFIELD	S. C. Sneeringer	Present	Present
GUERNSEY	James A. L. Toland	Present	Present
LICKING	R. G. Plummer	Present	Present
MORGAN			
MUSKINGUM	A. C. Ormond	Present	Present
NOBLE	Edward G. Ditch	Present	----------
PERRY	C. B. McDougal	----------	Present
WASHINGTON			
	NINTH DISTRICT		
GALLIA			
HOCKING	R. C. Jones	Present	Present
JACKSON	B. R. Allison	Present	Present
LAWRENCE	George N. Spears	Present	Present
MEIGS			
PIKE	A. M. Shrader	Present	----------
SCIOTO	O. D. Tatje	Present	Present
VINTON	H. D. Chamberlain	Present	Present
	TENTH DISTRICT		
DELAWARE	A. R. Callander	Present	Present
FAYETTE			
FRANKLIN	Wm. F. Bradley	Present	Present
	Helen P. Graves	Present	Present
	Warren G. Harding, II	Present	Present
	Charles W. Pavey	Present	Present
	M. P. Sayers	Present	----------
	Robert E. S. Young	Present	----------
KNOX	Henry T. Lapp	Present	Present
MADISON			
MORROW	Wm. Lowell Murphy	Present	----------
	Stanley Brody	----------	Present
PICKAWAY	Frank R. Moore	Present	Present
ROSS	Ralph W. Holmes	Present	Present
UNION	E. J. Marsh	Present	Present
	ELEVENTH DISTRICT		
ASHLAND	M. D. Shilling	Present	----------
ERIE	E. J. Meckstroth	Present	Present
HOLMES	N. P. Stauffer	Present	Present
HURON	C. J. Cranston	----------	Present
LORAIN	Chas. R. Meek	Present	Present
	Leonard A. Stack	Present	Present
MEDINA	John L. Jones	Present	Present
RICHLAND	C. O. Butner	Present	Present
	D. W. Dewald	Present	----------
WAYNE			
	OFFICERS		
President	Paul A. Davis	Present	Present
President-Elect	Merrill D. Prugh	Present	Present
Past-President	H. M. Clodfelter	Present	Present
Treasurer	R. L. Meiling	Present	Present
	COUNCILORS		
District			
First	D. W. Heusinkveld	Present	Present
Second	G. A. Woodhouse	Present	Present
Third	James R. Jarvis	Present	Present
Fourth	Paul F. Orr	Present	Present
Fifth	Charles L. Hudson	Present	Present
Sixth	C. A. Gustafson	Present	Present
Seventh	R. J. Foster	Present	Present
Eighth	Robert S. Martin	Present	Present
Ninth	C. L. Pitcher	Present	Present
Tenth	E. H. Artman	Present	Present
Eleventh	John S. Hattery	Present	Present
	Totals	122	106

Address of the President . . .

Trends of Today Require that Doctors Interest Themselves in Public Affairs on All Levels; Services Now Being Promoted Are Reviewed

By PAUL A. DAVIS, M. D., Akron, Ohio

(Presented to the House of Delegates, April 13, 1954, at Columbus)

IT has indeed been a great honor and pleasure to have served as your President during the past year. Year by year the problems with which your organization must concern itself are becoming more numerous, more complicated and require more and more time of the officers and committees.

We can no longer be complacent and we can no longer limit our activities to purely scientific discussions. The trends of today require that we as a profession interest ourselves in County, State, National and International affairs. We can no longer sit by and depend on some other person or persons to carry the ball for us. We have a job to do, so let us do it properly.

Before proceeding farther I would like to pay my respects to our esteemed Executive Secretary, Mr. Charles S. Nelson, and to his capable and efficient associates, Mr. George H. Saville, Mr. Hart F. Page and Mr. R. Gordon Moore; to Dr. Jonathan Forman, editor of *The Journal*; and to the entire clerical staff at the Columbus Office. Their excellent services and sound judgment keep the affairs of the Association running on a smooth basis. On behalf of the entire membership I wish to thank them and compliment them for their devotion to the activities of the Association and for the fine way in which they are meeting their duties and responsibilities.

Now let's take a bird's eye view of some of the activities and projects of our Association during the past twelve months.

PUBLIC RELATIONS

You know and I know that the maintenance of good relations with the public and creating better relationships between the medical profession as a group and the public are matters of supreme importance at this time.

Public relations is like the weather—everybody is talking about it. But unlike the weather—something can be and is being done about it.

In fact, the promotion of better relations between the medical profession and the public is one of the principal functions of the Ohio State Medical Association.

Public good will must be earned. It cannot be bought through huckster publicity either on the printed page or via radio and television, although these media can, and are, being used effectively to tell the public of medical advances and the constructive efforts of the medical profession to take better care of the people.

To earn and deserve public respect, your Association has urged all county medical societies to concentrate on a number of public relations activities. Most county societies have taken that responsibility seriously and have done something about it.

SPECIFIC PROJECTS

These activities include:

An emergency call service so that the public can be assured of service at night and on the doctor's day off;

A mediation or grievance committee to settle disputes between physician and patient;

Programs of school health and rural health;

Formation of community health councils;

Active participation in and professional guidance of all community health projects;

Radio and TV programs;

Health forums, in cooperation with local newspapers;

Health exhibits, speakers bureaus—and other PR vehicles to demonstrate that the doctor's interest in the public goes away beyond just keeping his patients well and being paid for it.

Your Association furnishes the ammunition to the county societies for the follow-through on these various PR projects. For example, the chairman of the public relations committee of each county medical society early this year received a comprehensive packet of "how-to-do" pamphlets and booklets, and a check-list to enable him to appraise the PR program of his society. Much of this material was obtained through the very active and effective Public Relations Department of the American Medical Association.

ROLE OF INDIVIDUAL DOCTOR

It may be trite to say it—but "Public Relations is Everybody's Business." It's the business of the A. M. A., the Ohio State Medical Association, each county medical society and most important of all—the business of every practicing physician.

Regardless of what our medical organizations accomplish in fostering better public feeling towards the medical profession, the average citizen is going to base his opinion of doctors on his personal experience with them. If, as he should be, Joe Citizen has been treated courteously, competently and considerately, he's a booster for

the medical profession; if the contrary is true—and unfortunately it occasionally is, the aggrieved patient is not in our corner—and we can't expect him to be.

I can assure you that the stimulation of good public relations will continue to be one of the top-priority projects of the Ohio State Medical Association. I urge you to insist that your county society do likewise. Incidentally it should include in its program, provision for the settlement of misunderstandings between physician and patient, as well as the disciplining of that small minority of members whose conduct casts a shadow on our profession.

COMMITTEES PRAISED

Much of the work of our Association is carried on through committees. Naturally, some of our 15 committees are more active than others. However, each of them has made some contribution to the over-all program of the Association during the past year. It is indeed heartening to know that between 100 and 150 busy physicians are so willing to make real sacrifices to carry out assignments which our committees must undertake under the general supervision of The Council. A few comments about a few of the activities of most of the committees will give you a better idea of the broad scope of the Association's efforts to do a job for the profession and the public.

RURAL HEALTH

The Committee on Rural Health has continued with the administration of the O. S. M. A. Rural Medical Scholarships. It is expanding the annual Rural General Practice Lecture Series for seniors in medicine at the Ohio State University from five to seven, and is preparing to discuss with Ohio's other two medical schools the possibility of starting the lectures there.

SCHOOL HEALTH

The Committee on School Health has been reorganized to provide at least one state committeeman in each councilor district, so that better field service can be rendered to local school health committees. The state committee is a co-sponsor of the first Ohio Conference on Physicians and Schools, which will be held May 11, 12 and 13 at Lake Hope. In addition, the committee is playing an active part in the joint campaign for the prevention of accidents to children, now in operation throughout the state.

EDUCATIONAL PROGRAM

Under the supervision of the Committee on Education, the Columbus Office assists county medical societies to secure speakers for county society meetings; supplies teams of speakers on specific subjects; and cooperates with other groups and organizations in making available postgraduate opportunities for physicians. Also, this committee acts in an advisory capacity on public health education activities, cooperating with public health agencies and organizations interested in carrying health information to the public.

GETTING THE FACTS

One of our most important committees is the Committee on Public Relations and Economics. It acts as a fact-finding and advisory group to The Council. The questions referred to this committee are varied in scope. Its recommendations are of extreme importance in determining the policies of the Association on many matters of vital concern to the profession. At present the committee is engaged in surveying and studying the public assistance laws and programs of Ohio. It hopes to have a report ready for The Council in the near future. A suggested Code for Autopsy Procedures was developed by the committee after many conferences with Ohio funeral directors, hospital representatives and pathologists.

WORKMEN'S COMPENSATION

The Committee on Industrial Health and Workmen's Compensation met nine times during the summer of 1953 for the purpose of reviewing the Workmen's Compensation Fee Schedule and the rules of procedure of the Industrial Commission. The recommendations of the Committee regarding fee schedule changes and certain rules of the Commission were adopted by The Council and submitted to the Commission. This committee is in constant touch with the Commission and acts as a liaison between the individual physician and the Commission on workmen's compensation matters. Moreover, it cooperates with all groups and organizations interested in better medical care for injured workmen and improved health conditions for the workers of the state at their places of employment.

CARE OF VETERANS

Due to the work and recommendations of the Committee on Medical Care of Veterans, the Veterans Administration recently increased some of the fees which it pays to physicians for services to disabled veterans. Jointly with the Committee on Public Relations and Economics and the Legislative Committee, the Committee on Medical Care of Veterans is cooperating with the American Medical Association in its efforts to bring to the attention of the profession, as well as the public, the need for changes in the Veter ans Administration set up, especially sections of the law and regulations dealing with medical and hospital services for veterans without service-connected disabilities.

LEGISLATIVE ACTIVITIES

I don't have to tell you about the fine work of our Legislative Committee. The outcome in favor of a number of complicated issues before the Ohio General Assembly in 1953 shows that the committee, with the help of our Columbus Office Staff and officers and legislative commit-

teemen of county medical societies, is on the job. Since national legislation has become of primary importance, this committee and committees of the local societies certainly have a 12-month responsibility year after year.

CHRONIC ILLNESS

Our Committee on Chronic Illness is working with other agencies and organizations on problems created by our ever-aging population and needs which must be met to provide better services and facilities for those with illnesses of long duration and those suffering from the degenerative diseases. It cooperated in planning for the recent State Conference on Problems of the Aging.

The Committee on Mental Hygiene is planning conferences with officials of the state department of public welfare in the very near future. Discussions will center around the state's hospital building program and policies for the handling of the mentally ill and mentally deficient citizens of Ohio.

NATIONAL DEFENSE

Civil Defense planning is primarily a local problem. However, our state Civil Defense Committee has endeavored to act in an advisory capacity and to keep local committees supplied with up-to-date data and suggestions.

Although the Korean mess is over, the nation still is engaged in a national preparedness program. This means that our Military Advisory Committee has to be maintained on a very active basis. All of you are familiar with the fine work which has been done during the past three years by that committee under very trying circumstances.

Three new committees have been established during recent months. They are: Committee on Maternal Health, Committee on Hospital Accreditation, and Committee on Interprofessional Relations on Eye Care. The names of these committees are descriptive of the character of their responsibilities and assignments. They are getting started in their work and will report later regarding their activities.

COLUMBUS OFFICE

It would be necessary to write a book—or two—to tell you about the many services rendered day after day, week after week and month after month by our Columbus Office staff. In addition to carrying on administrative details for The Council and all of our committees, the Columbus Office handles the Physicians' Placement Service; the work of the Speakers' Bureau; publication of *The Journal*; direct contact with the General Assembly when it is in session; liaison with the Chicago and Washington Offices of the A. M. A.; arranges for conferences with representatives of public and private agencies interested in medical-health-welfare questions and activities; supplies any or all of our 8,000 members with information on almost any subject on which a member may desire material or advice. It is indeed a gold mine of data and material, as many members have learned from experience. Those who do not make use of its valuable services are really missing a bet.

Obviously, many of the activities which I have already described require local support and local follow-up action. Therefore, each county medical society must have active local committees to carry on work which will supplement the work of the state committees.

OHIO MEDICAL INDEMNITY

Ohio Medical Indemnity, the prepaid medical care plan sponsored by the Ohio State Medical Association, continues to show a steady growth. It now provides coverage for 1,600,000 Ohio citizens and is the fifth largest Blue Shield plan in the country. It deserves the whole-hearted support of all of our 8,000 members. We should give O. M. I. a boost on every possible occasion. Ohio Medical does not attempt to set the physician's fee. By the same token, the physician should not increase his regular average charge for an O. M. I. subscriber—or in the case of any person receiving an insurance indemnity. Fortunately only a comparatively few physicians engage in this bad practice, but it takes only abuses and questionable practices on the part of a few to undermine confidence in the entire profession and in O. M. I. in particular. The officials of O. M. I. are endeavoring constantly to expand coverage, in fact, increases have been made each year since the company was founded nine years ago. At the same time, the company must be careful to maintain itself on a sound actuarial basis and must keep its rates at a figure within the pocketbook of the average subscriber.

POLITICAL ACTION

As you all know, this is an Election Year. In May, the voters will select party nominees; in November they will ballot on candidates for Congress, the Ohio General Assembly, executive offices, etc. Physicians as citizens must, therefore, become active in political affairs. It is the responsibility of their county medical societies to secure information about candidates, their views and attitudes on all public issues, including medical and health issues, and to see that physicians are supplied with such information. Only a well-informed person can vote intelligently. Speaking of voting, any citizen who fails to vote in these hectic times is not a good citizen. Each member of the Association should make sure that he is registered, if necessary, or otherwise qualified to vote. The same goes for each voting member of his family. The day has passed when the physician can sit on the sidelines and let others take an active part in public affairs, including politics—not politics in the partisan sense, but politics as it pertains to

nominating and electing qualified persons for all public offices.

NATIONAL LEGISLATION

A few moments ago I referred to national legislation. We have learned that what goes on in Washington has become everybody's business. Medical and health proposals are given high priority on the docket of Congress. This means that the medical profession must be alert and vigilant. Representatives of local medical societies and individual physicians must keep in close touch with Ohio's Congressmen and be prepared to give them the opinions of the medical profession on pending measures. Congressmen are anxious to know what the voters in their respective districts think about bills under consideration. We have a definite responsibility to make known our views and opinions. Let's not default.

MEDICAL EDUCATION

One of the most worthwhile projects of American medicine today is to encourage physicians to give more financial support to the nation's medical schools, either through the American Medical Education Foundation or through alumni funds.

During its three-year history the American Medical Education Foundation has contributed approximately 50 per cent of the $4,764,152.79 which has been distributed to the medical schools through grants made by the National Fund for Medical Education. The balance was obtained by the National Fund from business corporations and industries.

It is gratifying to report that last year 541 Ohio physicians contributed $25,938 to A. M. E. F., almost double the 1952 total of $13,177 from 265 contributors. In addition, many more of our Ohio colleagues made donations in substantial amounts directly to their own schools. While figures for 1953 are not yet available, it is expected that the 1953 total of alumni fund donors will at least equal, if not surpass, the 1952 total of 1,657.

I hope our members will make giving to medical education an annual habit. It's a good cause that vitally needs the liberal support of every physician.

AID OF COUNTY SOCIETIES VITAL

Most of the county medical societies are cooperating to the fullest extent with The Council and the various committees of the State Association, and with the Columbus Office staff. Were this not true, all phases of the Association's activity would suffer.

Therefore, I should like to thank the officers and committeemen, past and present, of the county medical societies for the fine help and support they have given to the State Association. In the end, they are vital cogs in the machinery which makes the Association click.

Also, at this point, I should like to thank and compliment members of The Council for their devotion and for their efficient services. Grappling with the many and intricate problems which arise within and outside the ranks of the profession is not an easy job; often it is a thankless one. Nevertheless, The Council has done everything possible to meet its responsibilities and to do a real job for all the physicians of Ohio. The Councilors merit the thanks and continued support of the membership generally.

WHAT OF THE FUTURE?

What about the future? The future is unpredictable. Prophets are notoriously unreliable. All I can say is that we may be able to exercise some control over the future and destiny of the medical profession if we are willing to face up to realities and meet our responsibilities. You know what the problems are. I have touched on many of them in these remarks.

In conclusion, permit me to make a few recommendations. As I do so I am aware of the fact that trends and situations change rapidly and that we have to be able to make quick adjustments. However, I believe my suggestions are broad and inclusive enough to help us accomplish our major objectives. I recommend:

1. That we increase the scope of our public relations and the scope of our professional relations.
2. That we devote more time and interest in government and legislative affairs—local, state and national—even international.
3. That we strive to develop closer cooperation between our county, state and national medical societies.
4. That we do everything possible to bring about closer cooperation and coordination between the medical profession and allied professional groups.
5. That we devote more time and thought to solving certain internal problems which are causing ill will and misunderstandings within the profession.
6. That we keep foremost in our minds the fact that we are obligated as physicians to give the public the best of medical care and health services and as citizens to work shoulder to shoulder with the people we serve for the best interest and welfare of the public generally.

It has been most gratifying to have had such fine cooperation during my term as president. To all who have assisted and advised me, I express my sincere thanks.

I sincerely hope that you and many others who have helped me will give individual and combined support to your incoming President, Dr. Merrill Prugh of Dayton, whose experience and ability qualify him to do an excellent job for you during the ensuing year.

Annual Meeting Attendance . . .

Total of 2,545 Persons Registered at Columbus Meet, April 12-15; Attendance by Counties Is Given with Roster of Members Present

AN excellent attendance was recorded at the 1954 Annual Meeting of the Association in Columbus, April 12-15, with a total of 2,545 persons. Following is the breakdown of this total: Members, 1,222; out-of-state physicians, 38; interns, residents and Ohio guest physicians, 159; medical students, 173; scientific and technical exhibitors, 252; Woman's Auxiliary, 327; miscellaneous guests, nurses, technicians, dentists, etc., 374.

Following are registration figures by counties, comparison of attendance at Annual Meetings from 1919 through 1954, followed by a roster of members present:

REGISTRATION, 1954 ANNUAL MEETING BY COUNTIES AND MEMBERSHIP DATA

County	Total Membership Dec. 31, 1953	Total Membership April 12, 1954	Annual Meeting Registration
Adams	10	11	2
Allen	94	101	22
Ashland	25	27	5
Ashtabula	52	56	4
Athens	30	31	6
Auglaize	18	17	3
Belmont	50	53	8
Brown	12	12	
Butler	137	136	7
Carroll	10	9	3
Champaign	18	17	5
Clark	116	110	28
Clermont	32	25	1
Clinton	25	25	10
Columbiana	70	59	9
Coshocton	21	22	9
Crawford	25	28	10
Cuyahoga	1,809	1,668	90
Darke	24	25	7
Defiance	16	16	2
Delaware	24	20	7
Erie	58	56	10
Fairfield	46	45	16
Fayette	13	13	6
Franklin	724	692	333
Fulton	23	22	1
Gallia	30	31	6
Geauga	12	12	2
Greene	39	38	6
Guernsey	31	33	4
Hamilton	1,073	1,0 3	75
Hancock	38	37	7
Hardin	25	23	7
Harrison	12	8	1
Henry	10	11	
Highland	19	21	10
Hocking	11	10	5
Holmes	9	7	2
Huron	22	22	1
Jackson	18	19	3
Jefferson	55	40	7
Knox	31	28	10
Lake	43	45	5
Lawrence	21	15	3
Licking	56	57	22
Logan	24	24	6
Lorain	140	132	9
Lucas	492	461	41
Madison	11	11	3
Mahoning	253	227	13
Marion	50	53	16
Medina	28	29	7
Meigs	7	10	5
Mercer	18	18	4
Miami	51	46	15
Monroe	4	4	
Montgomery	430	402	66
Morgan	6	5	2
Morrow	8	8	6
Muskingum	52	53	15
Noble	3	3	1
Ottawa	16	16	6
Paulding	11	11	1
Perry	13	11	2
Pickaway	16	15	4
Pike	9	9	4
Portage	33	32	5
Preble	12	12	1
Putnam	13	14	2
Richland	102	102	25
Ross	45	45	21
Sandusky	38	39	4
Scioto	67	66	14
Seneca	40	35	5
Shelby	16	18	9
Stark	276	277	23
Summit	390	380	42
Trumbull	98	98	9
Tuscarawas	52	50	12
Union	21	22	10
Van Wert	19	17	5
Vinton	3	3	1
Warren	14	14	3
Washington	26	26	7
Wayne	58	50	7
Williams	14	15	2
Wood	40	37	7
Wyandot	12	10	2
Totals	8,068	7,706	1,222

ANNUAL MEETING REGISTRATION FOR 1919-1954, INCLUSIVE

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.; Misc. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1813
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with A. M. A.						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			441	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545

Members of State Association Registered at 1954 Meeting

Adams County—S. J. Ellison, Hazel, L. Sproull.

Allen County—John D. Albertson, Andrew M. Barone, Fred P. Berlin, Arkley A. Dalton, William F. Foxx, K. G. Hawver, Howard G. Illig, Lawrence N. Irvin, Harold A. Lotzoff, Melvin A. Mulvania, Emmett Murray, Jr., Vernon A. Noble, Walter A. Noble, Franklin D. Rodabaugh, Maurice E. Scheetz, Alfred Schwerin, David L. Steiner, Herbert A. Thomas, Boyd W. Travis, Harold C. Weisenbarger, Edward B. Young, Carl H. Zinsmeister.

Ashland County—Herman M. Gunn, C. Glenn Paisley, Lorin G. Sheets, Myrtle D. Shilling, Wayne C. Smith.

Ashtabula County—J. Jason Dixon, Richard C. Irving, Eugene H. Merrell, Robert E. Stoops.

Athens County—Arthur L. Dobosiewicz, Hubert H. Fockler, Julien M. Goodman, Beatrice Postle, Clarence N. Sanders, John L. Webb.

Auglaize County—Clyde W. Berry, Edward E. White, T. H. Will.

Belmont County—Harry G. Harris, Bertha M. Joseph, Peter Lancione, Lewis L. Liggett, Nathan A. Masor, Harvey H. Murphy, Jack L. Paradise, Homer E. Ring.

Butler County—Harry L. Burdsall, Clyde G. Chamberlin, Jack L. Harris, Charles U. Hauser, William H. Henry, W. Fulton Hume, William U. Neel.

Carroll County—Thomas J. Atchison, Glenn C. Dowell, Carl A. Lincke.

Champaign County—V. R. Frederick, Joseph Friedberger, Forrest E. Lowry, I. Miller, John R. Polsley.

Clark County—Edwin E. Ash, Frederick A. Bavendam, Nial L. Burrell, John A. Davidson, J. Frederick Doyle, G. P. Fitzgerald, James G. Gianakopoulos, Wm. J. Habeeb, John F. Harley, Clarence W. Hullinger, A. Morton Karlan, Wesley E. Knaup, Robert A. McLemore, Louis H. Mendelson, William H. Miller, William P. Montanus, D. Joseph Parsons, Nicholas B. Pavlatos, Lillian M. Posch, Carl H. Reuter, Joseph H. Rinehart, E. L. Ringer, Geneva L. Shong-Rothemund, J. H. Shanklin, John M. Summers, Ray M. Turner, Ernest H. Winterhoff, S. C. Yinger.

Clermont County—Carl A. Minning.

Clinton County—H. Richard Bath, Richard R. Buchanan, Robert Conard, J. H. Frame, Roy D. Goodwin, W. Kelley Hale, Arthur F. Lippert, Ralph H. Vance, William L. Wead, Edmond K. Yantes.

Columbiana County—Wade A. Bacon, William S. Banfield, R. C. Costello, Alfons Philip Falkenstein, John A. Fraser, Virgil C. Hart, Raymond T. Holzbach, Wm. J. Horger, Anne I. Suliot.

Coshocton County—W. R. Agricola, J. Clifford Briner, Floyd W. Craig, Gerald A. Foster, Robert E. Hopkins, Robert R. Johnson, A. P. Magness, Howard H. Schwindt, Norman L. Wright.

Crawford County—Clarence Adams, Darrel D. Bibler, Edward C. Brandt, Mart L. Helfrich, Jr., Mart L. Helfrich, Sr., Martin M. Horowitz, John M. Kidd, Bernard M. Mansfield, Theodore D. Sawyer, Robert L. Solt.

Cuyahoga County—Paul H. Bade, Allan C. Barnes, Stacey A. Besst, Bernard L. Brofman, Joseph E. Brown, Francis L. Browning, John H. Budd, Thomas F. Charvat, Frank H. Clark, John H. Davis, Nicholas G. DePiero, R. S. Dinsmore, Fred W. Dixon, Wallace S. Duncan, Eduard Eichner, Charles W. Elkins, William J. Engel, A. Carlton Ernstene, Warren C. Fargo, G. Keith Folger, W. James Gardner, Thomas H. George, Donald M. Glover, Leona N. Glover,

Harry A. Haller, James R. Hart, John B. Hazard, James S. Hewlett, R. H. Hingson, Stanley O. Hoerr, Charles L. Hudson, David C. Humphrey, C. R. Jablonoski, Sidney Katz, Walter R. Katzenmeyer, Fred R. Kelly, Roscoe J. Kennedy, Clifford L. Kiehn, J. C. Kloepfer, George R. Krause, Henry E. Kretchmer, Michael J. Krisko, John H. Lazzari, Fay A. LeFevre, Samuel C. Lind, Chester R. Lulenski,

Bernard S. Malasky, John W. Martin, Paul A. Mielcarek, Paul G. Moore, Walter Musta, Paul A. Nelson, Richard N. Nelson, Robert H. Nuss, George W. Petznick, Herman D. Pocock, Jr., Egon E. Pribram, Walter H. Pritchard, Hyatt Reitman, R. Richard Renner, Edw. C. Roy, George W. Ryall, Jr., Herbert W. Salter, Brant B. Sankey, Roy W. Scott, Edward W. Shannon, Thomas A. Shehan, Keith W. Sheldon, F. A. Simeone, Harry W. Slade, James E. Slivka, Earl E. Smith, Walter M. Solomon, Wess E. Sroub, Sewell K. Starcke, Bruce B. Sutton,

Robert D. Taylor, George A. Tischler, Bert A. Treister, Rupert B. Turnbull, Jr., Samuel L. Vinci, Andre A. Weil, Herman C. Weinberg, Herbert J. Weiss, Beulah Wells, R. J. Whitacre, Julius Wolkin, Harry T. Zankel, Walter J. Zeiter, Henry A. Zimmerman.

Darke County—Emmett W. Arnold, V. Ray Boli, E. Westbrook Browne, Maurice M. Kane, John S. Meyers, Peter H. Mulder, Ross M. Zeller.

Defiance County—Dyle J. Slosser, Harold J. Wenzinger.

Delaware County—Adelbert R. Callander, Maynard S. Cherington, Donald L. Gantt, Edward C. Jenkins, M. W. Livingston, F. M. Stratton, Tennyson Williams.

Erie County—John R. Dickason, Wm. F. Burger, Wm. T. Fenker, Seldon R. Hoover, Ross M. Knoble, David R. Lehrer, Henry G. Lehrer, Emil J. Meckstroth, Lester G. Parker, Dean Sheldon.

Fairfield County—Hubert M. Amstutz, Charles F. Clark, Frederick W. James, Wm. S. Jasper, George F. Jones, A. M. Kelley, Victor N. Kistler, George W. LeSar, Jr., Elson D. McCullough, Wilford D. Nusbaum, Carl R. Reed, Galon S. Rodabaugh, E. B. Roller, Stanley C. Sneeringer, Chester P. Swett, Kenneth W. Taylor.

Fayette County—Marion D. Gamble, Joseph M. Herbert, Jack H. Persinger, Marvin H. Roszmann, A. D. Woodmansee, Robert D. Woodmansee.

Franklin County—Kenneth H. Abbott, Benj. W. Abramson, Louis Adelman, Tibor Agoston, Louise P. Ainsworth, Marion L. Ainsworth, T. Allenbach, James M. Andrew, Neil C. Andrews, Shirley Armstrong, Ben Arnoff, Drew J. Arnold, Perry R. Ayres, Calvin L. Baker, Beatrice Bamberger, Howard W. Bangs, Charles W. Barch, M. L. Battles, H. C. A. Beach, H. G. Beatty, William R. Beery, Floyd M. Beman, Casper H. Benson, Raymond W. Bethel, Walter L. Boenheim, G. H. Bonnell, Sr., R. W. Bonnell, Howard E. Boucher, Wade D. Bower, Wm. F. Bradley, Paul E. Brady, Richard I. Brashear, Wayne Brehm, Margaret W. Bridwell, B. J. Brief, John E. Briggs, Grace Nunemaker Brown, Harold E. Brown, John E. Brown, Jr., John Q. Brown, R. A. Bryce, Alethea J. Buccalo, Maurice G. Buckles, Olan P. Burt, Alice M. Bustin,

Wm. R. Calland, Ben B. Caplan, William H. Carter, Lewis W. Cellio, Ivor G. Clark, H. Wm.

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Byron E. Neiswander, Carl Nohe, Thayer L. Parry, Edgar C. Pickard, Marshall J. Pierson, Jr., Reuben R. Pliskin, John G. Repasky, William B. Rogers, Jr., John P. Sauvageot, Louis Sheinin, Hazel P. Simms, Fred F. Somma, J. E. Springer, Edw. L. Voke, Frank M. Warner, Laurence M. Weinberger, Marshall R. Werner, Jefferson C. Woodbury.

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Wayne County—Matthew Marks, J. Wylie McGough, Adrian J. Hartzler, Joel F. Pratt, Richard W. Reiman, Vincent C. Ward, Ralph H. Zemer.

Williams County—Paul G. Meckstroth, John R. Riesen.

Wood County—Halford E. Whitacre, Sigmund A. Kosewick, Francis J. Nemcik, Edith M. Offerman, Paul F. Orr, John Victor Pilliod, Frederick F. Price.

Wyandot County—Richard L. Garster, Franklin M. Smith.

A. M. A. Inaugural Ceremonies To Be Televised

The inaugural ceremony at which Dr. Walter B. Martin, Norfolk, Va., will be installed as the 108th president of the American Medical Association will be broadcast over a nationwide radio network on Tuesday, June 22.

Originating at 7:30 p. m., Pacific Coast Daylight Saving Time, (10:30 p. m. Eastern Daylight Saving Time) from the Palace Hotel in San Francisco, the program will be carried by more than 350 stations of the American Broadcasting Company's radio network. This will be the fifth consecutive year an A. M. A. president has addressed the nation on the night of his inauguration.

In addition to Dr. Martin, other A. M. A. officers who will appear on the radio and television broadcasts are Drs. Dwight H. Murray, chairman of the Board of Trustees; Edward J. McCormick, outgoing President, and James R. Reuling, speaker of the House of Delegates.

Jenkins Bill, H.R. 10 . . .

Excellent Statement as to Why It Should Be Enacted Inserted by Ohio Congressman in Congressional Record; Measure of Vital Interest to Doctors

WHETHER or not H.R. 10, the so-called Jenkins-Keogh Bill, which should be of vital interest to physicians and many other self-employed persons, is enacted into law at this session of the Congress, will depend largely on the degree of enthusiasm and interest displayed by physicians and others in requesting their respective Congressmen to take an active interest in support of the proposal.

After reading excerpts published here, from a statement inserted in the *Congressional Record* of April 26, 1954, by Congressman Thomas A. Jenkins, Ironton, Ohio, one of the authors of H.R. 10, physicians should write to their Congressman, urging him to give his support to the measure, if they believe it is desirable legislation.

In his statement in the *Congressional Record,* Congressman Jenkins reviews briefly some of the provisions of the Social Security Law which provides benefits for employed persons. Then, he discusses at length the need for legislation which would make it possible for self-employed persons to gain some income tax relief for premiums paid by them into voluntary retirement insurance programs—which is the objective of H.R. 10. Mr. Jenkins statement, in part, was as follows:

POSITION OF SELF-EMPLOYED

"The OASI (Old Age and Survivors' Insurance) program as originally enacted did not include the self employed. Even under our present Social Security Act, as amended, there are many categories of employed and self-employed persons who are denied OASI coverage. Many of the large corporations and employers of labor provided their own retirement programs whereby many employees were given security coverage.

"In spite of this very general trend toward security coverage there remain many thousands of our people who are not included under our social-security protection and who are not given the opportunity of providing for their own retirement through plans approved under the Internal Revenue Code. These persons have come to the conclusion that their best relief will come if they entered into a plan of self-insurance. Already many persons who do not qualify under any plan, presently in force, have come to the conclusion that they owe it to themselves and to their families to guard against the vicissitudes and uncertainty of life. It is to meet this demand that the Jenkins bill, known as H. R. 10, was introduced in the present Congress.

"The Jenkins bill, H. R. 10, will give to self-employed persons and others not eligible under existing law to be covered by an approved retirement program, the opportunity to establish their own individual retirement plans. H. R. 10 would give to these taxpayers benefits comparable to those available to corporations and their employees under section 165 of the Internal Revenue Code. This section of our tax laws provides that employees participating in plans approved under the statute do not have to include the employer's contribution to a retirement program in their gross income for tax purposes until pensions are actually received. Company contributions are deductible by the company in the year in which made.

TAX DEDUCTIBLE

"H. R. 10 would allow eligible persons to exclude from their gross income limited amounts paid into a restricted retirement plan or toward the purchase of a restricted retirement annuity contract. Annuity payments received under this program would be fully taxable. A qualified individual under my bill is defined as one "not eligible to participate in a pension or profit-sharing plan qualified under section 165 or established by a governmental or charitable employer." It thus covers employees of corporations or partnerships which have no qualified plan. It would also cover owners of small businesses, professional people, and farmers. The amount deductible in any 1 year cannot exceed 10 percent of earned income or $7,500, whichever is less, and there is a lifetime limitation of $150,000. I stress the fact that my bill would merely give to millions of our taxpayers benefits that are comparable to those already received by other millions of American taxpayers.

"I shall not go into a further discussion of the bill. Much has been written about it. One of the most lucid and convincing articles that I have seen is an editorial that appeared in the current issue of the Saturday Evening Post published under date of April 24. This is not simply a news article but is instead a considered opinion based on careful analyses of the issues and equity involved. It is an editorial that has been written by a man who recognizes that there is one more important step that must be taken before the security of a great and responsible group of our people has been provided. This

editor puts himself and his very popular and widely circulated magazine on record as supporting the lawyers, doctors, dentists, farmers, and many thousands of our best citizens in their desire to establish security for themselves and their families.

"This editorial is as follows:

Why Not Encourage the Self-Employed To Build Their Own Retirement Funds?

" 'Employed persons in the United States are at least partially protected for their old age by social security. In addition, many of them are the beneficiaries of company pension funds. Payments into such funds by employers, as well as the employers' share of the social security tax, are deductible from taxable income. Up to now, however, there is no similar provision for a large group of self-employed people, such as physicians, lawyers or farmers. Their efforts to provide for retirement are hampered by exorbitant taxation.

" 'In the Philadelphia area recently, a physician enjoying a large and presumably profitable private practice retired and took a job in a Government hospital. He gave as his reason for doing so the fact that he had been unable to educate his children and at the same time save enough to provide for eventual retirement. He felt himself compelled to become an employed person in order to receive the benefits of a pension fund. A young doctor or lawyer, after a long and expensive education and apprenticeship, is likely to find adequate saving almost impossible under present conditions.

" 'Congress is now considering a measure which is designed to fill some of these gaps. The Jenkins-Keogh bill, which was introduced last year, is an outgrowth of several efforts to solve the problem. In general, it provides that any individual who is not eligible to participate in a pension or profit-sharing plan may set aside each year an amount not to exceed 10 percent of his earned income, and in no case more than $7,500, to be paid into a restricted retirement trust or insurance annuity. The amount thus set aside could be deducted from his taxable income. The proposed law places certain restrictions on the means by which these savings can be accumulated and provides that the taxpayer may not tap the fund until he is 65 years old, "except in the case of total disability." This would place him roughly on the same footing with employed individuals who are the beneficiaries of private pension funds.

NO FAVORITISM

" 'Undoubtedly the proposed measure does give the self-employed certain other advantages over their opposite numbers in the ranks of the employed. For example, the beneficiary of some company pension funds may not accept a job in another company without forfeiting his equity in a pension from his first employer. The self-employed doctor who builds up his own retirement fund may leave his community and set up shop somewhere else and still hang on to his retirement allowance. There are undoubtedly other discrepancies, but if an individual can do better on his own account than through a company pension fund, this might be an important step away from the welfare state. Private saving should be made at least as attractive as reliance on contributions by employers or the Government.

" 'Few reliable estimates have been made of the possible loss of revenue to the Government if such a law were passed. However, as a writer in the *Harvard Law Review* has observed, "even the possibility that the revenue loss would be so considerable as to necessitate higher tax rates is not a valid objection; it seems more equitable to distribute the tax burden among all taxpayers than to continue discrimination against one group.' "

Eligible Interns, Residents Advised To Seek Commissions Immediately

Interns and residents who are liable for military service upon completion of their schooling this summer are advised to seek immediate commissions so that there will be no long waiting period before they are called. The advice was relayed to Military Advisory Committee Chairmen of Ohio by Dr. Drew L. Davies, Columbus, chairman of the Ohio Advisory Committee to Selective Service and chairman of the Ohio State Medical Association's Military Advisory Committee.

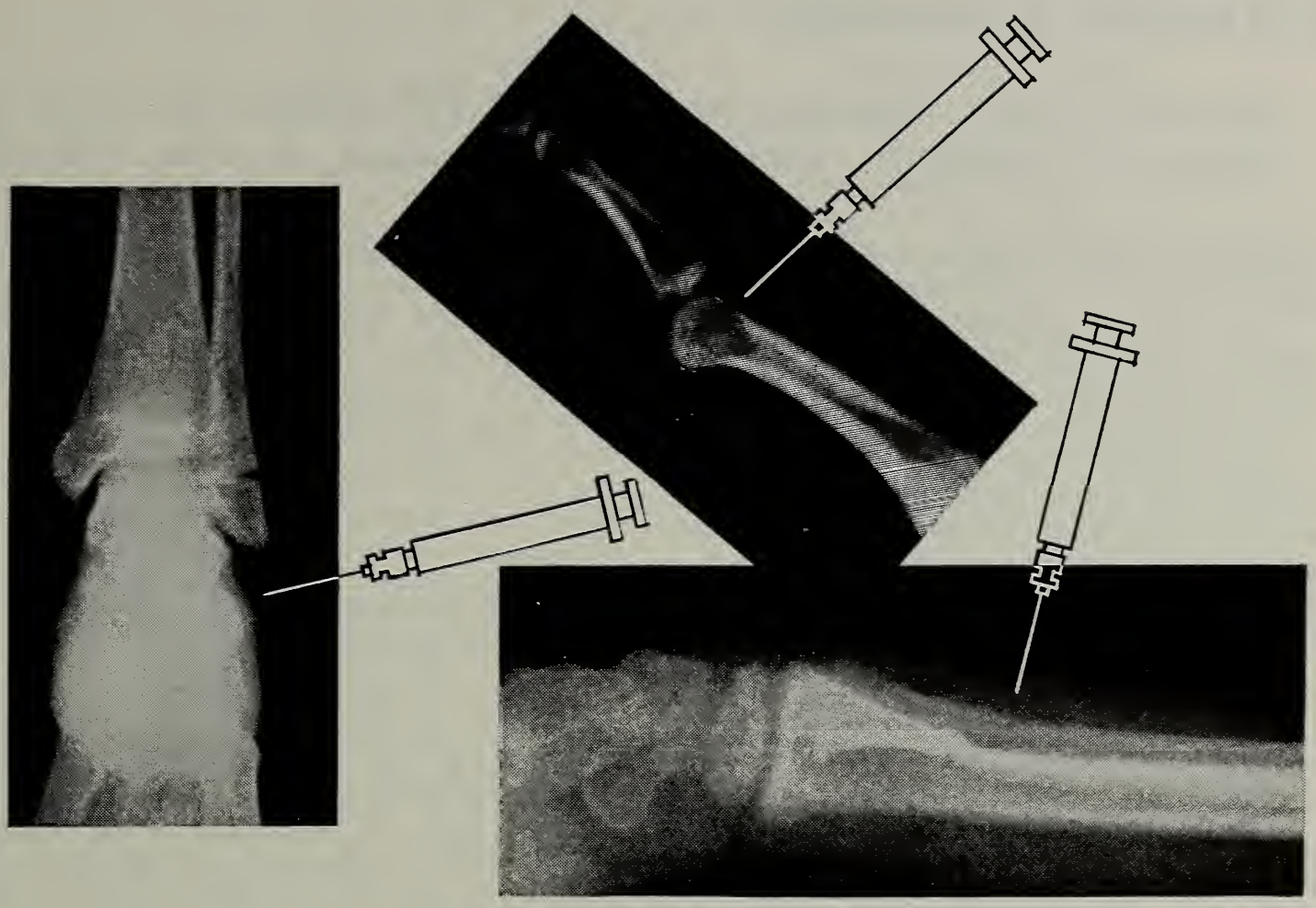
The original communication on this subject came from the National Advisory Committee to the Selective Service System in Information Release No. 15, which reads as follows:

Subject: Commissions and Liability for Service.

"The requirements of the military services for physicians between July 1, 1954, and June 30, 1955, are such that all who have obligations for military service in Priority I and Priority II and that portion of Priority III born after August 30, 1922, will, in all probability, be called to duty.

"Due to new processing regulations it will take much longer to issue commissions after applications are filed than in recent months. Therefore, every effort should be made to have those physicians who will finish internships and residencies by July 1 apply at once for commissions so there will not be a protracted period of waiting between the end of the hospital year and the call to active duty. The only exceptions to the above are those cases of individual physicians who occupy positions that have been declared essential in medical practice in remote communities or those physicians who hold essential positions on medical faculties.

"Anything you can do to facilitate this program will be most helpful and deeply appreciated."



Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

In traumatic surgery[1] where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means[1, 2] of accelerating dispersion of accumulated fluids.

Swenson[2] has described his highly successful results with Alidase in various types of closed wounds. He summarized them as follows:

To remove local fluid accumulations in contusions or bruises, "The usual dose, 500 viscosity units Alidase® mixed in a small amount of normal saline, is injected into the localized fluid. Mixing the hyaluronidase in 1 per cent procaine solution will also produce local vasodilatation, relief of local pain and more rapid absorption of the fluid mass. This method can also be applied to traumatized bursae or synovial spaces which do not respond to repeated aspirations."

The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anesthesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

Fluids administered with Alidase are rapidly absorbed from subcutaneous tissue. The simplicity of hypodermoclysis avoids the cumbersome arm board, permits convenient administration with little or no pain or swelling, is vein-sparing and saves nursing time in such conditions as burns, postoperative states, toxemias and parenteral alimentation.

Alidase (brand of hyaluronidase) is supplied in serum-type ampuls of 500 viscosity units. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1 MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, J. Bone & Joint Surg. *35-A*:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, Am. J. Surg. *87*:384 (March) 1954.

Gamma Globulin . . .

Announce Larger Allocation for Ohio's Use This Season; Recommended Dosage Is Increased; Application of Procedure in Ohio Outlined

OHIO'S initial allocation of gamma globulin designed for use in the prevention of paralytic poliomyelitis is approximately 400,000 cc., or about twice the initial allocation last year, Dr. John D. Porterfield, director of the Ohio Department of Health, reported.

Approximately 70,000 cc. additional has been allocated for use in prevention of measles and infectious hepatitis. Supplemental allocations will be made to Ohio during the 1954 season on the basis of the number of reported cases of these three diseases.

The following information on the distribution of g. g. in Ohio was contained in a recent memorandum sent to local health commissioners by Dr. Porterfield:

Prior to the announcement that the State's allocation had been increased the Office of Defense Mobilization reached an agreement with the Association of State and Territorial Health Officers, National Foundation for Infantile Paralysis and the American National Red Cross concerning the conditions of allotment. The four main points of this agreement are:

1. That gamma globulin be used in paralytic poliomyelitis prevention only in the inoculaton of groups larger than a single family unit.

2. That each state health officer make the decision for his jurisdiction as to the definition of groups which will be eligible for inoculation.

3. That the recommended average dose of 7 cc. used during 1953 be increased to 10 cc. for the 1954 season.

4. That gamma globulin shall not be used in areas in which the poliomyelitis vaccine field trials are being conducted.

The decision not to use the restricted household contact method of allocation is based upon the report of the National Advisory Committee for the Evaluation of Gamma Globulin of January 29, 1954, which has been summarized in the *Journal of the American Medical Association*, Volume 154, No. 13, (March 27, 1954). It was concluded in this report that the dosages utilized last year the inoculation of household contacts of reported cases of poliomyelitis had no significant influence on: (a) the severity of paralysis developing in subsequent cases, (b) the proportion of non-paralytic cases among the subsequent cases who received gamma globulin before onset, (c) the classical pattern of familial aggregation of cases in the country at large.

On April 8, 1954, a special meeting of the Infectious Disease Committee of the Health Commissioners' Conference was called to assist in formulating the recommended methods of allocation which will be utilized in Ohio this season. The following methods of allocation are based upon recommendations made by this Committee:

Method of Allocation of Gamma Globulin in Ohio During 1954:

INFECTIOUS HEPATITIS

The use of gamma globulin in the prevention of infectious hepatitis should be encouraged. Primarily it should be allocated for use in household contacts of known cases of this disease. However, in instances where epidemics are occurring in elementary schools, consideration should be given to the mass inoculation of schoolroom populations. Requests for globulin for this purpose should be made to the Ohio Department of Health.

MEASLES

Gamma globulin should be made available for all children who are contacts of measles where the physician considers modification or prevention indicated. It should not be used for adults except in the case of pregnant females.

POLIOMYELITIS

1. Gamma globulin will be distributed to all health jurisdictions on the basis of their population and their poliomyelitis incidence during the last five years. The initial allocation will amount to approximately twice the amount of the initial allocation of last year. Supplementary allocations will be made as needed during the course of the season.

2. The local health commissioner will be responsible for the allocation of gamma globulin within his jurisdiction. It is strongly recommended that each health commissioner present the problem to his local medical society and that a method of allocation acceptable to the health department and to the medical society be agreed upon.

Following the occurrence of a case of poliomyelitis in the health jurisdiction, it is suggested that gamma globulin be made available to physicians whose patients may have been a contact of this case. Gamma globulin should not be

withheld from the family contacts of the case if the physician wishes to administer it, but the allocation under no circumstances should be restricted to the household members. It is also suggested that there be limited publicity concerning the program and that gamma globulin for paralytic poliomyelitis prevention be distributed only to those physicians who request it.

3. The dosage of gamma globulin should be calculated on the basis of 0.20 cc. per pound of body weight. Representative dosages would, therefore, be:

Weight	Dosage
25 lbs.	5 cc
50 lbs.	10 cc
100 lbs.	20 cc
150 lbs.	30 cc

4. It is recommended that some age limitation be placed upon the allocation of gamma globulin for paralytic poliomyelitis prevention. It is suggested that the eligible age group include those persons over three months of age but under 30 years of age. An exception to this limitation would be pregnant women who are contacts. They should be eligible at any age.

5. Each health commissioner should be aware of the results of the National Advisory Committee evaluation and call to the attention of their physicians the summary of this evaluation as published in the *Journal of the American Medical Association.*

6. A reasonable amount of gamma globulin will be kept in reserve in the Ohio Department of Health. This will be used for special epidemic situations and for further study of the best method of utilization of gamma globulin.

7. Gamma globulin for use in paralytic poliomyelitis prevention will not be available to those areas in which poliomyelitis vaccine field trials are being conducted.

Ohio Heart Association Elects Officers

At its annual meeting held in Columbus on April 15 the Ohio State Heart Association elected the following officers and members of the Executive Committee for the coming year: Dr. R. W. Kissane, Columbus, president; Irving B. Hexter, Cleveland, chairman of the Board; Mrs. O. W. Haulman, Youngstown, secretary; Charles W. McCoy, Columbus, treasurer; Dr. A. Carlton Ernstene, Cleveland; H. Willis Nichols, Jr., Cincinnati; Drs. J. Paul Sauvageot, Akron; Maurice A. Schnitker, Toledo; Bernard A. Schwartz, Cincinnati.

The seventh annual meeting of the American Association of Blood Banks will be held in the Shoreham Hotel, Washington, D. C., September 13-15. Additional information may be had from the Association at 3500 Gaston Ave., Dallas, Tex.

Polio Vaccine Field Trials Proceeding in Ohio

Approximately 300 physicians in Richland and Montgomery Counties—Ohio's two test counties in the nation-wide poliomyelitis vaccine field trails—have inoculated 16,772 volunteer children, reported Dr. John D. Porterfield, director of the Ohio Department of Health.

The program, under sponsorship of the National Foundation for Infantile Paralysis, is designed to test on a large scale the effectiveness of the new vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The trials in Ohio are under supervision of the Ohio Department of Health with cooperation of local medical societies and health departments.

The study in Ohio is being conducted under strictly controlled conditions with one-half of the participants (in grades 1 to 3) receiving the new vaccine and one-half receiving a placebo solution. The immunization schedule provides for a series of three doses of 1 cc. each to be given to each child intramuscularly in the arm. The first two sensitizing doses are administered one week apart, while the third, or booster dose, is given four weeks following the second injection.

Reports from physicians in the test areas indicate that no reactions to the vaccine or placebo material have been encountered, Dr. Porterfield said.

Dr. Porterfield reported that the Richland and Montgomery County Medical Societies have given their wholehearted endorsement to this program and that the individual members of these societies have enthusiastically volunteered their services in administration of the vaccine.

Supplemental Grant Given for Polio Studies in Cincinnati

Supplementing its December grant, the National Foundation for Infantile Paralysis announced an additional $64,840 to aid with polio research conducted jointly by the University of Cincinnati College of Medicine and the Cincinnati Children's Hospital Research Foundation. The studies are under direction of Dr. Albert B. Sabin. The December grant was for $87,566, which makes the total $155,406.

Interest in group practice has been on the upswing in the United States since World War II. Since little information is available on the subject, A. M. A. has authorized study employing personal interviews.

Eight Visits



How many times have you put your hands to your head (after seeing all the detail men in your office) and said, "Why don't they tell me they're coming?" Breon men do. They call every six weeks, eight times a year. No more. This way, you save time and trouble. You buy just what you want without costly overstocking. And more important, you don't find yourself short on an item you may need right away. Breon men are friendly without being overfamiliar . . . helpful without being overbearing. The Breon man in your neighborhood will be glad to introduce himself. Just send this ad attached to your RX or letterhead to Geo. A. Breon & Co., 1450 Broadway, New York 18, N.Y.

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Medical Care For Military Dependents . . .

Proposal Sponsored by Defense Department Introduced in Senate; Differs in One Major Respect From Policy of A.M.A. and O.S.M.A.

JUST a little more than a year ago, the Moulton Commission started its study of medical care for military dependents. After a series of hearings, it made its report in June, 1953. The long-delayed bill to implement the recommendations contained in the report has just been introduced in the U.S. Senate. (S. 3363 by Senator Saltonstall, R.-Mass.)

In many respects the proposal is in line with the policy of the American Medical Association and the Ohio State Medical Association regarding dependent care.

NOT IN LINE WITH A.M.A. POLICY

However, on one basic point there is disagreement, namely: The Defense Department would have dependents receive private medical and hospital care **only if they could not be provided in military facilities** and S. 3363 contains that provision. The A.M.A. and the O.S.M.A. would have dependents use military facilities **only if care is not available from private sources.** The difference is obvious.

It would be well for all physicians to familiarize themselves with this proposed legislation. Even if nothing is done at this session of the Congress, medical care for military dependents will continue as an issue.

ANALYSIS OF BILL

Drafted by and introduced at request of Defense Department, this S. 3363 is designed to provide a "uniform program of medical care for dependents" as an important factor in Armed Forces morale. Currently, extent of medical care to dependents varies geographically and within the services. The bill provides:

Medical Care Authorized: Diagnosis, acute medical and surgical conditions, contagious diseases, immunization, and maternity and infant care.

Not Authorized: Hospitalization for domiciliary care and chronic diseases, nervous and mental disorders (except for diagnosis), "elective medical and surgical treatment." No prosthetic devices, hearing aids, orthopedic footwear or spectacles, except abroad or at remote stations, when sale would be at cost; no home calls except in special cases; no ambulances, except in acute emergency.

No dental treatment in military facilities, except emergency care or as necessary adjunct to medical treatment or at remote stations and abroad. No dental care from **private sources,** except as necessary adjunct to in-patient medical treatment.

Civilian vs. Military Care: Dependents to be cared for by civilian physicians and at civilian hospitals only if care is not adequate or available in military facilities. Amount of care to be provided by military would be "subject to availability of space, facilities and capabilities of medical staff." Except for charges to dependents noted below, U.S. would pay civilian physician and hospital costs, in line with a fee schedule to be set by Defense Secretary who may consult with medical and other groups on the schedule.

What Dependents Pay: When care is from **civilian sources,** dependents pay first $10 for each illness (except maternity), and in addition, not more than 10% of total cost; **in military installations,** Defense Secretary to set charges to dependents, "pursuant to a special finding that such charges are necessary." Subsistence in connection with medical care to be paid for as prescribed by regulations. U.S. to stand balance of expense.

Dependents Defined: Declared to be eligible for care are the wife, unmarried children, adopted or step children under 21, and those over 21 if physically or mentally incapacitated and dependent on service member for over half support; parents and parents-in-law if dependent for over half of their support; widows and dependent children of members who die while eligible under the act (but such dependents eligible only for care in military facilities).

"Members of Armed Forces" Defined: All persons on active duty in three services (and Coast Guard when operating as part of Navy); reserves on extended active duty of more than 90 days; retired members of services, except those retired on reserve retirement point program. The Secretary of Defense is authorized to promulgate regulations subject to approval by the President.

HEALTH GRANTS BILL PASSED BY HOUSE

On April 27 the House passed by voice vote the Public Health Service grants bill, H.R. 7397, with committee amendments. The bill was amended to maintain mental health grants as a separate category for five years. Reason given: The magnitude of the mental health problem, the early stages of the program, and separate mental health divisions in several states make it advisable to earmark appropriations for those activities. The amendment thus continues for five years the present system for dealing with mental health grants. Other grants would be disbursed according to a new plan. The committee also

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amended the bill to give the states the right of judicial appeal, as in the Hill-Burton Act.

CLINIC LOAN BILL IS OPPOSED

A statement has been filed with Congress by the American Medical Association opposing H. R. 7700 which would authorize the Federal Government to provide mortgage loan insurance for hospitals, clinics and other medical facilities, used in connection with voluntary health plans or operated on a fee-for-service basis. This is not an Administration Bill. It is receiving substantial backing from Henry Kaiser and others who favor group practice clinics and insurance programs in connection with the operation of such clinics.

The A.M.A. statement stated in part:

A.M.A. STATEMENT

"The stated purpose of the bill is to amend the Public Health Service Act to provide mortgage loan insurance for hospitals and other medical facilities used in connection with voluntary prepayment health plans.

"The bill would seek to achieve this purpose by authorizing the Surgeon General of the United States Public Health Service to provide, through the mechanism of a Federal Medical Facilities Mortgage Insurance Fund, federal mortgage insurance of private loans for the construction of additional hospitals and related medical facilities supplying voluntary, prepayment, group practice medical care. It provides further that the aggregate amount of all outstanding mortgages could not exceed one billion dollars, except that the President could authorize an increase of an additional one quarter billion.

"In view of the aggregate amount of outstanding mortgages authorized to be insured, it is quite obvious that this bill contemplates something far broader than an experimental program.

"The American Medical Association is opposed to the proposal for a number of reasons, the first and most important of which is the fact that there is no proved need for this type of legislation. To the extent that it would provide guaranteed loans for the establishment of 'personal health service centers' and 'offices for physicians and dentists' it definitely represents intrusion by the federal government into a field where the job is now being done adequately by private enterprise. Even in the smallest communities, experience has demonstrated that ample funds are available for these purposes from private sources, and that there is no need or desire for federal governmental guarantees.

"On the contrary, our records indicate many examples of communities building facilities to attract young physicians and providing agreeable arrangements with regard to rentals and purchase. This is a growing practice in remote areas.

"Another of the stated objectives of the bill is to encourage group practice or, more precisely, 'to increase the opportunities and facilities by which doctors may associate themselves together in groups, partnerships, and other private initiative arrangements.' The question immediately arises as to the advisability of enacting legislation through which the federal government will throw its weight behind a particular form of medical practice, i.e., group practice, as against the individual practitioner. We do not consider this advisable, and urge that the implications of such a policy be thoroughly explored prior to any action in this respect. The American Medical Association, representing as it does over 140,000 physicians, many of whom are in group practice and many of whom are in solo or individual practice, considers it inadvisable for the federal government to enact legislation favoring a particular segment of the profession.

"For the foregoing reasons, the American Medical Association does not recommend favorable consideration of H.R. 7700, 83rd Congress."

Don Ebright Honored with National Award of Cancer Society

The "Man of the Year National Award" for outstanding effort in cancer control was presented this year to Don H. Ebright, Cleveland, chairman of the Board of Trustees, Ohio Division, American Cancer Society. Mr. Ebright is vice-president of the Union Bank of Commerce, Cleveland, and former treasurer of the State of Ohio.



Mr. Ebright is shown (left) as he received the "Man of the Year National Award" from Dr. Lazzari.

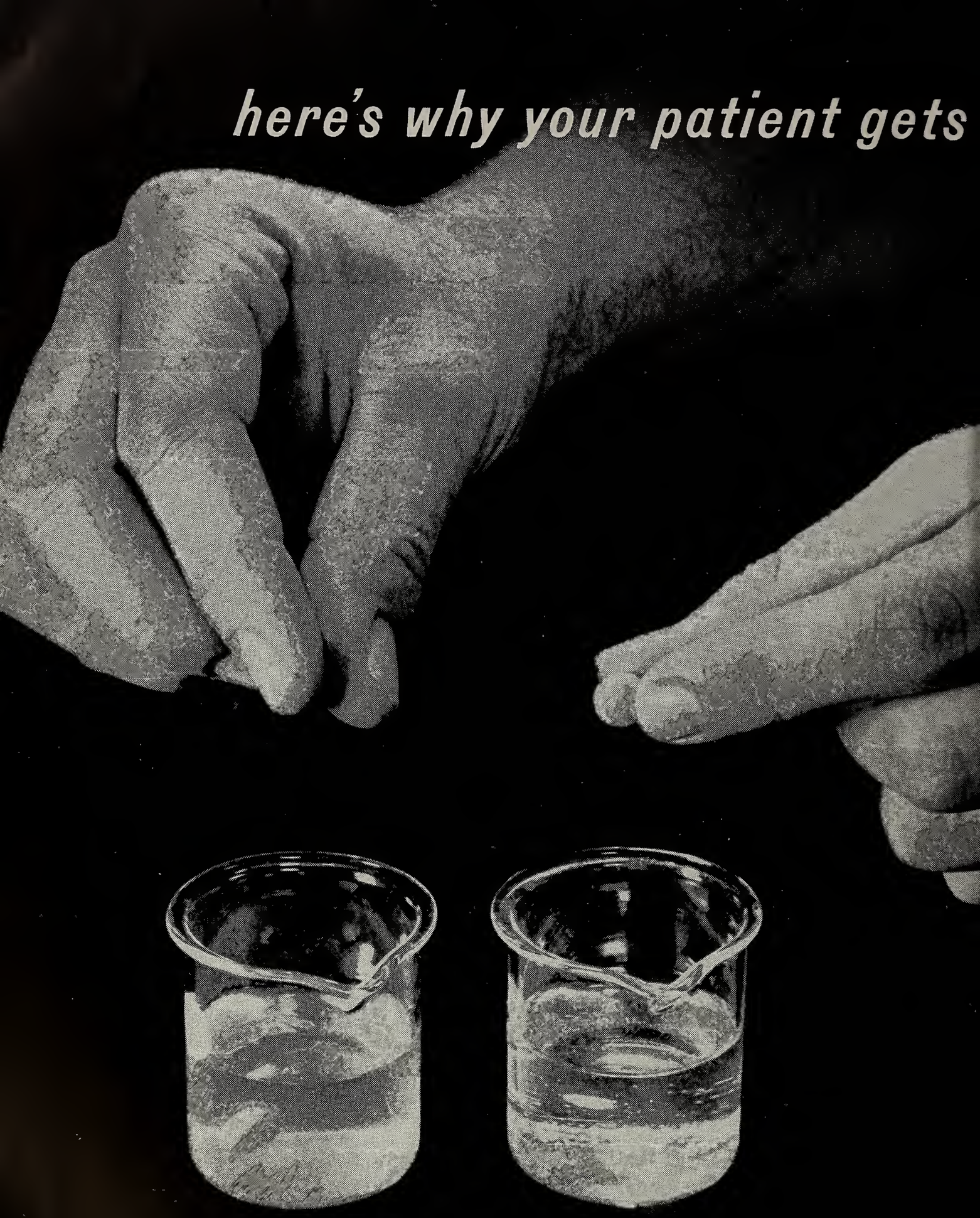
Mr. Ebright has been actively engaged as an officer of the Cancer Society since 1945. The Society has grown to where now there are units in each of the 88 counties in the State.

The award was presented to Mr. Ebright by Dr. John H. Lazzari, Cleveland, president of the Ohio Division, on behalf of the National Society. Dr. Lazzari is a member of the subcommittee on cancer of the Ohio State Medical Association.

Dental Medicine

The next annual meeting of the American Institute of Dental Medicine will be held at the Desert Inn, Palm Springs, Calif., October 31-November 4. Full information may be had from the Executive Secretary, Miss Marion G. Lewis, 2240 Channing Way, Berkeley 4, Calif.

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3:15—Disintegration Test begins in actual stomach fluids (pH 2.7). Beaker at left contains ordinary enteric-coated erythromycin. At right is new *Film Sealed* ERYTHROCIN Stearate (Erythromycin Stearate, Abbott).

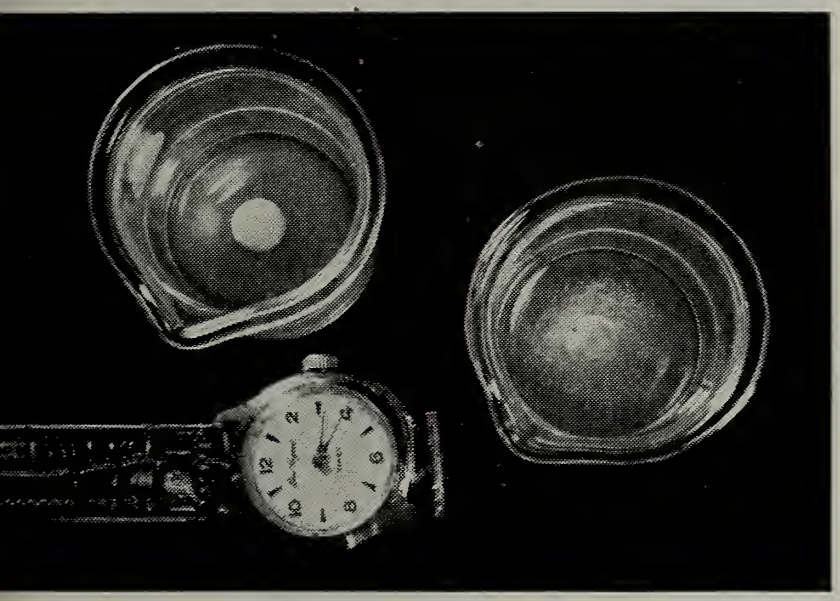
Earlier Blood Levels *from*

FILM SEALED* **ERYTHROCIN**

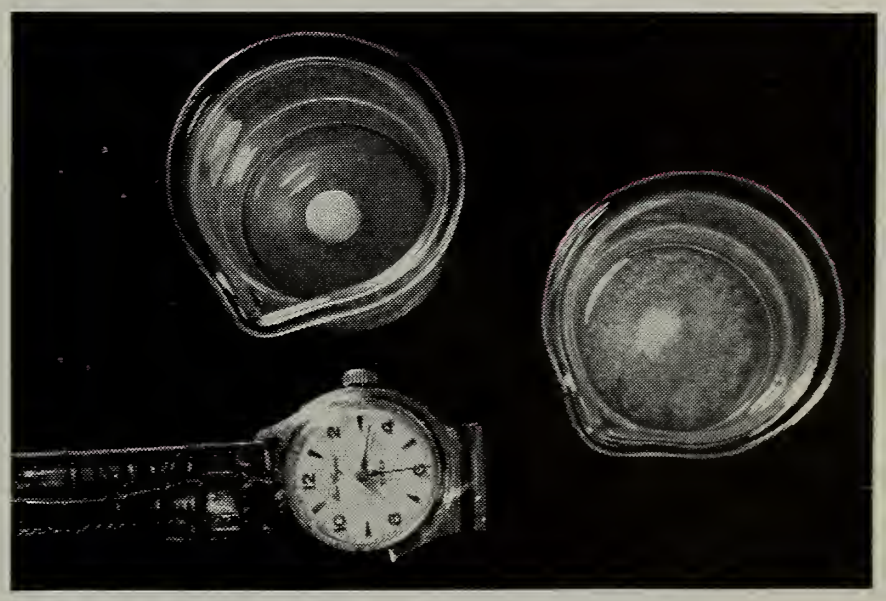
TRADE MARK

DISINTEGRATES FASTER THAN ENTERIC COATING

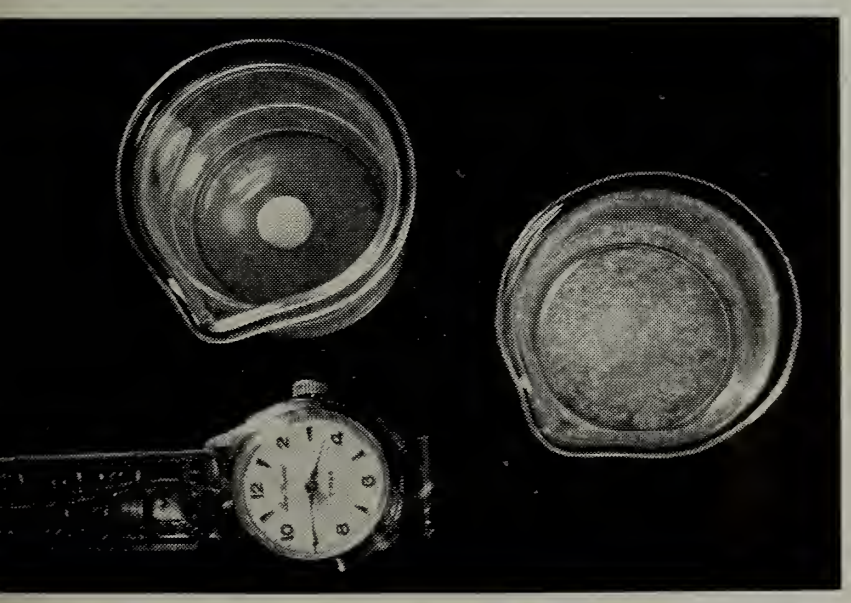
HIGH BLOOD CONCENTRATIONS WITH 2 HOURS



:20—Five minutes later, *Film Sealed* coating has already tarted to disintegrate. The tissue-thin film actually begins o dissolve within 30 seconds after patient swallows tablet.



3:30—*Film Sealing* is now completely dissolved. At this stage, ERYTHROCIN is ready to be absorbed, and ready to destroy sensitive cocci—even those resistant to most other antibiotics.



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4:00—Because of *Film Sealing* (marketed only by Abbott) the drug is released faster, absorbed sooner. In the body, effective ERYTHROCIN blood levels now appear *in less than 2 hours* (instead of 4-6 hours as before).

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Ohio Medical Indemnity . . .

Report Shows Continuing Increase in Number of Persons Covered by Company; Officers Elected; Other Facts About Year's Operations

AN ADDITIONAL 191,846 Ohioans were enrolled by Ohio Medical Indemnity during 1953. That brings the total membership to 1,606,726 as of December 31, 1953, or one of every four residents in the 83 counties served by O. M. I.

This was reported at a meeting on April 21 of stockholders of O. M. I., the medical and surgical coverage plan operated by the Ohio State Medical Association.

The 21 incumbent members of the Board of Directors were reelected by vote of the stockholders to serve an additional year. They are: Robert T. Allison, M.D., Akron; A. A. Brindley, M.D., Toledo; H. M. Clodfelter, M.D., Columbus; R. Dean Dooley, M.D., Dayton; Charles N. Hoyt, M.D., Chillicothe; James S. Mathews, M.D., Wyoming; Carll S. Mundy, M.D., Toledo; George Sackett, M.D., Cleveland; L. Howard Schriver, M.D., Cincinnati; C. C. Sherburne, M.D., Columbus; Robert G. Smith, M.D., Circleville; Edmond K. Yantes, M.D., Wilmington; Starling C. Yinger, M.D., Springfield; C. H. Campbell, Columbus; D. A. Endres, Youngstown; James B. Fenner, Toledo; Clair E. Fultz, Columbus; Edgar W. Jones, Canton; Charles Mills, Marysville; Harold W. Slabaugh, Akron; David L. Temple, Dayton.

ELECTION OF OFFICERS

Dr. Mundy was elected President of the Corporation to succeed Dr. Schriver. Dr. Schriver, who had served in that capacity since 1946 when O. M. I. was organized, asked to be relieved of the duties of President. Dr. Mundy, also a charter member of the Board of Directors, has served as chairman of the Executive Committee, since O. M. I. began business and had been Vice-President of the Company.

Dr. Sherburne was elected Vice-President of the Organization and chairman of the Executive Committee. The following directors, in addition to Dr. Sherburne, compose the Executive Committee: Drs. Allison, Clodfelter, Dooley, Hoyt, Sackett and Yantes, and Messrs. Fultz and Slabaugh.

Other officers elected are: Mr. Charles H. Coghlan, Executive Vice-President; Mr. Charles S. Nelson, Secretary-Treasurer, and Mr. Frank Van Holte, Assistant Treasurer.

SUMMARY OF INCREASES

The following information is contained in the 1953 Annual Report submitted by Mr. Coghlan, to the Board of Directors:

Income for the year reached $11,433,000, an increase of $2,000,000 over 1952.

Monthly income for December, 1953, exceeded for the first time $1,000,000.

Total assets amounted to $7,548,000, an increase of $1,810,000.

Incurred claims reached $8,843,000, or 78.13 per cent of subscription income.

Total number of claims in 1953 was 163,693.

An average of 15,000 claims were handled each month.

Claim payments reached an average of $40,000 daily.

Administrative expense dropped to 10.53 per cent.

Montgomery County continues to lead with 61 per cent of its population covered by Ohio Medical Indemnity.

Final plans for a home office building in suburban North Columbus were completed. A three-story, 80 by 100 foot structure will be ready for occupancy in late 1954 or early 1955.

ADDITIONAL CONTRACTS

The Preferred Surgical Anesthesia Contract completed its first full year in 1953. Slightly over 9,000 contacts covering 23,000 members were added during the year. The Preferred Contract provides higher indemnity payments for surgical services and the maximum benefit was raised from $200 to $300. In addition, anesthesia, when administered by a physician, is considered a benefit and is paid on a specific schedule. Groups covered under the Standard Contract were given a choice of transferring to the new contract with an increase in charge to the subscriber.

The Non-Group Contract (individual contract) was offered in two other Blue Cross areas, Lima and Toledo, in addition to the Columbus area. Total enrollment in the Non-Group contract now stands at 6,700.

The In-Hospital Medical Care Plan was added to a number of existing groups, as well as being delivered to new groups, so that at the year's end, 215,000 subscribers were protected for in-

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Taste CO-SALT and know why this different salt substitute so truly satisfies the cravings of your low-sodium diet patients for the flavor of salt.

CO-SALT so closely looks like, sprinkles like and tastes like salt . . . there is . . .

1. **no "cheating" on the prescribed diet**
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Lithium-free, never bitter or metallic in taste, contains nothing that may deplete the system of phosphorus or other minerals. The only salt substitute that contains choline. For use at table or in cooking.

in congestive heart failure

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hospital non-surgical illnesses, as well as surgery and obstetrics.

In 1953, the general reserve was increased to an amount recommended by the National Association of Insurance Commissioners for companies of this classification.

Total number of Americans now carrying Blue Shield coverage throughout the nation as of the end of the year was $28,250,000.

1954 INCREASED INDEMNITIES

The foregoing report covered activities to the end of 1953. The following increases in indemnities were put into effect April 1, 1954, without any increase in subscription rates (old indemnities shown in parentheses):

Excision of pilonidal cyst	$ 60.00	($50.00)
Operative cystoscopy	$ 50.00	($35.00)
Repair of cystocele with rectocele	$100.00	($75.00)
Extraction of crystalline lens	$100.00	($75.00)
Fractures:		
Radius & Ulna, simple	$ 50.00	($35.00)
Tibia & Fibula, simple	$ 75.00	($50.00)
Mandible	$ 40.00	($25.00)

Also effective April 1, was an increase in benefits for subscribers covered by the O. M. I. Medical Expense Indemnity Rider. This is the rider covering hospitalized medical (non-surgical) admissions. Coverage has been extended from 30 days to 70 days at no increase in subscription fees. Subscribers will now receive $5.00 per day for the first two days and $3.00 per day for the next 68 days when they are hospitalized with medical illness conditions.

Recent Legal Opinions Given By the Attorney General

Recent opinions given by Attorney General C. William O'Neill concern interpretation of certain provisions of the new food service licensing and inspection law; payment for certain patients at the Ohio tuberculosis hospital, and support by county commissioners of regional civil defense organizations.

FOOD SERVICE LICENSING

The Syllabus of Opinion No. 3700, given by the Attorney General on April 6, reads as follows:

1. An operation conducted by a state agency which otherwise meets the requirements of a food service operation is subject to the provisions of Sections 3732.01 to 3732.08, inclusive, of the Revised Code.

2. An operation conducted on state-owned property by lessees, concessionaires, or contractors of the state, which operation otherwise meets the requirements of a food service operation, is subject to the provisions of Sections 3732.01 to 3732.08, inclusive, of the Revised Code.

3. The provisions of Sections 3732.01 to 3732.08, inclusive, of the Revised Code, do not apply to food service operations where such operations are located on land owned by the United States and over which the United States has acquired exclusive jurisdiction.

4. A place where food is served and which in other respects meets the requirements of Section 3732.01, Revised Code, is a food service operation, within the meaning of the definition contained in such section, only when it is held out to the public to be a place where meals or lunches are served for a consideration; a county children's home or county infirmary does not constitute such a food service operation where the food service normally is only for those employed or kept at the institution.

TUBERCULOSIS HOSPITALS

The Syllabus of Opinion No. 3646, given by the Attorney General on March 26, reads as follows:

1. The provisions of Section 3701.60, et seq., Revised Code, relative to the expense of care and treatment of patients admitted to the Ohio tuberculosis hospital, and of Section 339.20, Revised Code, relative to the expense of care and treatment of patients in local tuberculosis hospitals, considered in pari materia, indicate a legislative policy that such patients, or persons legally responsible for their support, should be required to reimburse the county for the cost of hospitalization in such institutions if they are financially able to do so.

2. The county commissioners may investigate the financial status of applicants for admission to the Ohio tuberculosis hospitals, and of persons legally responsible for the support of such applicants, and may require such reimbursement in proper cases as a condition of their approval of applications for admission to such hospital.

3. Where a patient in the Ohio tuberculosis hospital has been admitted therein without a requirement by the county commissioners of such reimbursement, and where no such reimbursement arrangement is currently in operation, and where such patient is subsequently found not to have tuberculosis but is continued temporarily in a patient status under the provisions of Section 3701.65, Revised Code, the expense of such continued hospitalization is to be met from state funds available to such hospital.

CIVIL DEFENSE

The Syllabus of Opinion 3683, given by the Attorney General on March 31, is as follows:

Under the provisions of Section 5915.11, Revised Code, a board of county commissioners is authorized to make appropriations for the support of a regional organization for civil defense where such organization has been created under the provisions of Section 5915.07, Revised Code, through participation of the county concerned.

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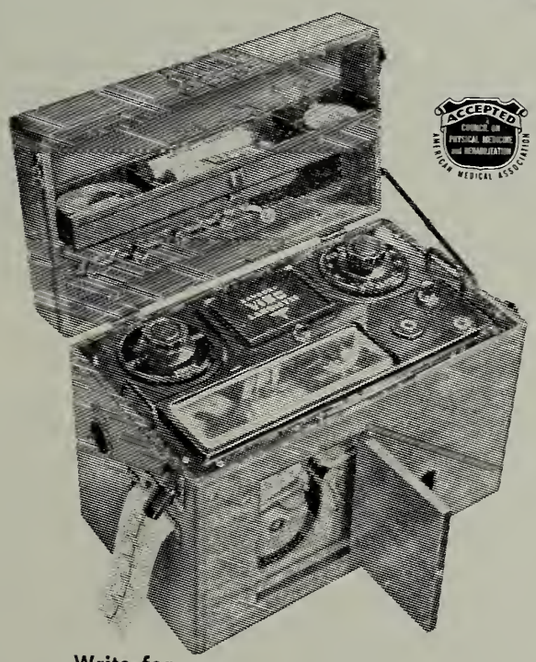


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"Who Says Wrong Again?" . . .

The Toledo Times Backs A.M.A. Position on Reinsurance Proposal and Takes Issue With *The Toledo Blade* Which Says A.M.A. Is "Wrong Again"

SHORTLY after the American Medical Association informed the Congress that it could not endorse the so-called voluntary health plans reinsurance proposal pending in Congress and asked that the Social Security Act not be amended to make it mandatory for physicians to take OASI coverage, *The Toledo Blade* carried a highly critical editorial, labeled, "Wrong Again."

Seven days later, *The Toledo Times* published an editorial, captioned "Who Says Wrong Again?" It took the position that the A. M. A. policies on the measures were sound and logical.

The Blade piece inferred that the A. M. A. should be for the reinsurance proposal because people are tired hearing the A. M. A. yell about socialized medicine. Obviously, it hardly makes sense to suggest that sin be opposed in one breath and approved in the next.

On the other hand, *The Times* made a logical, sensible analysis of the A. M. A. point of view and said it believed the A. M. A. position is sound. Here's what *The Times* editorial writer wrote:

Who Says, Wrong Again?

"During the past few days the American Medical Association has again been attacked as an enemy of the common man, an opponent of social progress and, in general, a prehensile organization interested only in the fees of its members.

"Specifically, it has been attacked for opposing the Administration's program to spend $25,000,000 to reinsure voluntary health insurance schemes and to set up a system of compulsory social security for the members of the medical profession. The AMA is 'wrong again' say the critics, among them our confreres across the tracks, who made an eloquent, if rather dubious point, by saying the doctors should know the only way to protect themselves against socialization of medicine, with strict government control over their practices, is to go along with the Administration in its program.

LACK OF UNDERSTANDING

"All we can say to our brethren, as well as the other critics of the AMA, is this: they speak out of a complete lack of understanding of the stand taken by the association. It is obvious that they have not read, in detail, the evidence submitted to the House Commerce Committee a few days ago, else they would not have condemned the association as they did.

"We have read, carefully and completely, the testimony submitted to the committee, first by Dr. David B. Allman, of Atlantic City, and, next, by Dr. F. L. J. Blasingame, of Wharton, Tex. We can find nothing in it to prove that the AMA is hell bent for fighting public health insurance. On the contrary, the evidence reveals clearly that the association is in favor of it, but not as a Federal proposition. Well, what's wrong with opposing Federal reinsurance? To be honest, nothing. A little study by the association's critics would prove that.

EMPHASIS ON VOLUNTARY

"To begin with, the AMA approves of all voluntary health association programs. It speaks of the great growth of such schemes in recent years, and pledges itself to promote their further development. It is, indeed, engaged in a plan to make them effective, particularly in the protection of the indigent people of the nation, who, after all, are the ones who really need the insurance.

"The difference between the AMA and the Administration, in promoting health insurance, is this: it believes that any governmental support should be on the state and local level. In other words, it maintains that the states and municipalities, not the Federal Government, should underwrite all health insurance plans, if they are to be guaranteed. With this in mind, the association already is establishing a field service of experts to assist state and county medical societies in developing programs of guaranteeing medical services to the people.

LOCAL RESPONSIBILITY

"What is wrong with making the states and municipalities responsible for such programs? Nothing. It is the states, not the Federal Government, which are responsible in the matter. It is the states which should act, simply because, as sovereign political entities, they are closer to the people. Besides, the first responsibility is theirs. What's more, the Federal Administration itself long since recognized the fact that the central government should not assume the responsibility for such programs. Under President Eisenhower, the tendency in U. S. aid programs is to return to the States complete control of the various social and welfare programs that have become so much a part of American life.

"The AMA is supported in this by the insurance companies of the land. These companies maintain that reinsurance by the Federal Treasury does not 'increase the ability of the insurer to sell protection to the unwilling buyer.' Neither



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does it reduce the cost of health insurance. Neither does it make 'insurance available to any class of risk or geographic area not now within the capabilities of voluntary insurers to reach.' Nor does it reduce the cost of health insurance.

GOVERNMENT SUBSIDY

"What it means, at bottom, is a type of government subsidy, such as the Treasury now pays to farmers. But this is the sort of thing the American people have been trying to get away from. Well, then, the matter is clear: voluntary insurance cannot possibly relieve a community of the burden of providing medical care to the indigent, and reinsurance by the Federal Government does not enhance the power of the insurers to guarantee it. When all comes to all, the Eisenhower program becomes a burden on the taxpayers without any assurance that the program will succeed. Moreover, it runs the risk of placing all voluntary insurance plans under the control of bureaucrats.

"As to the AMA's opposition to compulsory social security pensions for the nation's physicians, we can say only that criticism of it is preposterous. In short, the opposition is wholly within the concept of the American system of free enterprise. It is based on the right of every individual to make his own plans for life. It represents individualism at its best. The doctors say simply that they prefer to provide their own insurance. Every taxpayer should welcome such a stand. Certainly, it entails no burden on the taxpayers, as every other scheme of social security does.

"Considering all this, we think the critics of the AMA are both foolish and inept in their stand. Even a long-embraced whipping boy deserves more honest treatment than this."

Fort Steuben Academy Holds Monthly Program

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, was one of the speakers at the May 11 meeting of the Fort Steuben Academy of Medicine in Steubenville. His subject was "The Cytopenic State—Its Causes and Treatment." The other speaker on the same subject was Dr. William M. Cooper, director of the Central Blood Bank, Pittsburgh, Pa. Dr. Laura K. Mesaros, Steubenville, was chairman of the floor discussion.

Cincinnati—Dr. Jack Hertzman, of the Division of Health and Hygiene, Cincinnati Public Schools, recently by invitation took part in a work conference with the New York Board of Education Curriculum Research Division. The study toward possible improvement in curriculum was done under the auspices of the New York State Department of Education and State Mental Health Department.

Licensed Through Endorsement by State Medical Board

The State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians through endorsement of their licenses to practice in other states (intended residence and medical college of graduation also are given):

January 26, 1954—Joseph E. LaBarre, Hopedale, Harvard Medical School; **Eamonn P.** O'Kelly, National University of Ireland (Dublin); Douglas A. Sargent, Chillicothe, University of Michigan.

April 13, 1954—Walter M. Anglin, Cleveland, Western Reserve Univ.; Michael A. Anthony, Columbus, Georgetown Univ.; Lionel G. Barraza, Parma, Louisiana State; Betty J. Beauge, Columbus, Woman's Medical College of Pennsylvania; Evelyn M. Bellaire, Youngstown, Medical College of Virginia.

Saul C. Bookspan, Toledo, Chicago Medical School; Joseph E. Boyer, Springfield, Meharry Medical College; Manfred Braun, Chagrin Falls, Univ. of Graz (Austria); Merton E. Burhans, Lakewood, Univ. of Illinois; John T. Burroughs, Akron, Harvard Medical School.

Charles O. Carothers, Cincinnati, Harvard Medical School; William S. Caudell, Dayton, Univ. of Rochester; William F. Collins, Jr., Cleveland, Yale Univ.; William J. Corzine, Jr., Chillicothe, Univ. of Maryland; Frank H. Critchfield, Jr., Cleveland, Univ. of Pittsburgh; George H. Davies, Toledo, Univ. of Nebraska; Morris S. Dixon, Jr., Wooster, Univ. of Rochester.

Wesley B. Elstun, Cincinnati, Northwestern Univ.; Ralph A. Eskesen, Columbus, Johns Hopkins Univ.; Paul E. Frye, Akron, Univ. of Maryland; William F. Gebhart, Cleveland, Univ. of Pennsylvania; Robert B. Gilbertson, Fremont, Univ. of Tennessee; David Gitlin, Youngstown, Univ. of Lausanne (Switzerland); Francisco Gonzalez, Canton, The Medical College of Virginia.

Oscar A. Hardin, Cleveland, Howard Univ.; William S. Harper, Berea, Long Island College; Robert C. Hunter, Akron, Univ. of Maryland; Shelby E. Jarrell, Marietta, Medical College of Virginia; John R. Jones, Columbus, Univ. of Michigan; William J. Keating, Lakewood, Univ. of Michigan; Louis L. Keppler, Jr., Cleveland, St. Louis Univ.; John E. Kicos, Cleveland, St. Louis Univ.

Richard N. Land, Dayton, Indiana Univ.; Fred H. Landeen, Youngstown, Creighton Univ.; Benjamin H. Landing, Cincinnati, Harvard Medical School; John J. Leahy, Univ. of Louisville; Alfred E. Leiser, Cleveland, Univ. of Wisconsin; Charles F. Lester, Yale Univ.; Holton C. Letson, Zanesville, Univ. of Nebraska; George Lockhart,

(Continued on Page 620)



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III, Shaker Heights, Univ. of Pennsylvania; Frank P. LoFiego, Toledo, St. Louis Univ.

Robert A. McDougal, Akron, Indiana Univ.; Charles N. Manley, Cincinnati, Univ. of Tennessee; John L. Mantica, Mingo Junction, St. Louis Univ.; William D. May, Univ. of Tennessee; Stephen Mazzola, Dayton, Long Island College; Eugene E. Mihalyka, Cleveland, Medical College of Virginia; John G. Monyak, Middleport, George Washington Univ.; Elliott V. Mosley, Columbus, Univ. of Kansas.

Hans Neuer, Chillicothe, Univ. of Vienna (Austria); Vaun A. Newill, Cleveland, Univ. of Pittsburgh; Richard J. Nowak, Cleveland, Univ. of Rochester; Cyril P. O'Boyle, Cleveland, Univ. of Pennsylvania; Richard C. Oudenhoven, Toledo, Marquette Univ.; Daniel F. Paul, Jr., Bellevue, Hahnemann Medical College; Dogan M. Perese, Dayton, Southwestern Medical School; Myron H. Powelson, Zanesville, Univ. of Louisville; Thomas N. Quilter, Marion, Loyola Univ.

Daniel J. Radecki, Toledo, St. Louis Univ.; Philip Ramer, Lakewood, Univ. of Toronto; Edward K. Reid, Syracuse Univ.; Filmore Schiller, Euclid, Univ. of Illinois; Robert R. Simner, Dayton, The Chicago Medical School; Buel S. Smith, Cleveland, Univ. of Pennsylvania; Gerald Stark, Toledo, St. Louis Univ.; Frank J. Staub, Jr., Elyria, New York State Univ.

George D. Talbott, Dayton, Columbia Univ.; George Tchakmakoff, Cincinnati, Univ. of Goettingen (Germany); Robert G. Thompson, Cincinnati, Med. Col. of the State of South Carolina; Heino Trees, Cincinnati, Univ. of Heidelberg (Germany).

Jacob Wachtel, Cleveland, Univ. of Vienna (Austria); Thomas M. Walker, Dayton, Indiana Univ.; Kernoyler Webb, Jr., Cleveland, Howard Univ.; Robert D. Weekley, Cleveland, Univ. of Maryland; Lewis E. Wells, Jr., Springfield, Univ. of Pittsburgh; George W. West, Jefferson Med. College; Robert R. Williams, Middletown, Univ. of Louisville; Abraham Wolkin, Hamilton, Univ. of Bern (Switzerland); Frederick C. Wyttenbach, Indiana Univ.; George Zubowicz, Lima, Univ. of Vienna (Austria).

Name Successor to Dr. Crosby

The appointment of Dr. Kenneth B. Babcock, Detroit, as director of the Joint Commission on Accreditation of Hospitals has been announced by Dr. Newell W. Philpott, Montreal, commission chairman. Dr. Babcock, who resigned as director of Grace hospital in Detroit, will succeed Dr. Edwin L. Crosby, newly-appointed executive director of the American Hospital Association.

The Joint Commission is sponsored by the American College of Physicians, American College of Surgeons, American Hospital Association, A. M. A. and the Canadian Medical Association.

Do You Know? . . .

Dr. G. W. Flory, Eaton, recently resigned as Preble County coroner at the age of 92, after many years in that office. His successor is Dr. C. M. Treffinger, also of Eaton.

* * *

Dr. Richard W. Vilter, University of Cincinnati, presented a paper before the Federation of American Societies for Experimental Biology's American Institute of Nutrition in April in Atlantic City, N. J. He reported success in preventing the development of toxic symptoms in treating tuberculosis with a new anti-TB drug isoniazide. His work in Cincinnati is supported by a research grant from the National Vitamin Foundation.

* * *

Dr. Louis H. Bauer, former President of the American Medical Association, has been elected Chairman of the Board of United Medical Service, New York's Blue Shield Plan.

* * *

George H. Saville, Director of Public Relations, Ohio State Medical Association, spoke on "You and Your Public," at the Sixteenth Annual Convention of the Ohio Association of Accident and Health Underwriters held at Columbus, May 14.

* * *

Dr. Richard A. Kern of Philadelphia has assumed the presidency of the Society of Medical Consultants to the Armed Forces.

* * *

Ohio physicians and their wives who attend the American Medical Association Session in San Francisco have an invitation to visit the home of Dr. and Mrs. Joseph A. Maxwell, 7390 Cabrillo Avenue, La Jolla, Calif. Dr. Maxwell, a graduate of Ohio State University College of Medicine, is at present doing a tour of duty with the Army in Italy.

* * *

Two papers by Dr. Ira A. Abrahamson, Jr., now chief resident in ophthalmology at Cook County Hospital, Chicago, will appear in the *American Journal of Ophthalmology*. They are "Acute Ophthalmoplegia," presented before the Chicago Ophthalmological Society, and "Anterior Segment Photography," read to the Grand Rounds in the hospital. He also presented a paper, "Acute Emergencies of the Eye," to the Chicago Chapter, American College of Surgeons." He will return in the fall to Cincinnati to practice with his father, Dr. Ira A. Abrahamson, Sr.

* * *

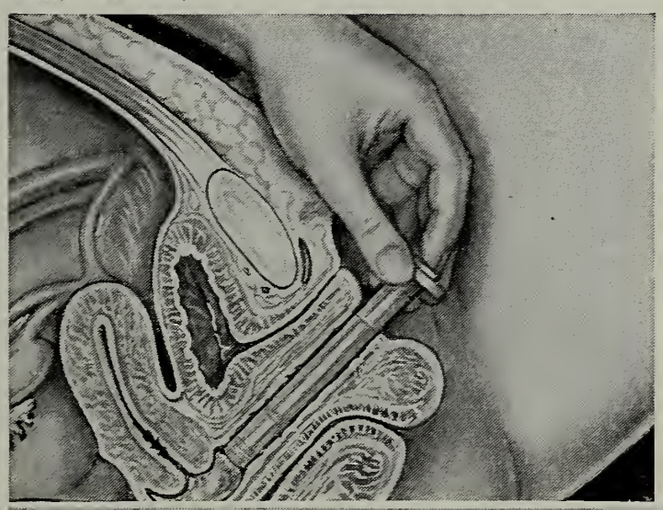
New manager of the 3,445-bed Veterans Administration Center at Dayton is John I. Spreckelmyer, formerly manager of the V. A. center at Bath, N. Y. He succeeds B. C. Moore, who retired.

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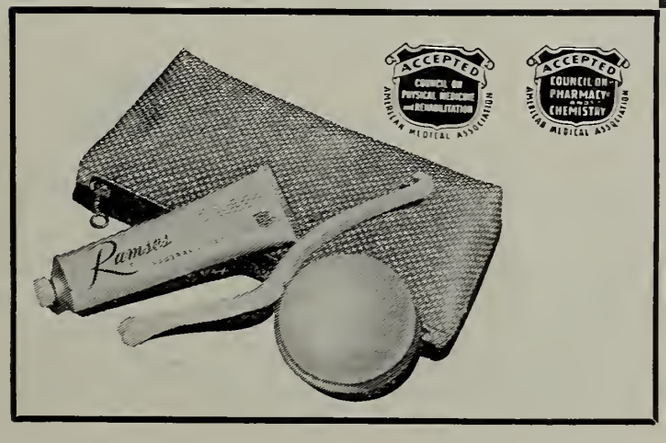


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Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Pending on the U. S. Supreme Court docket is the case of a San Diego man who holds that fluoridation of the city's drinking water violates the fourth and tenth amendments to the Constitution of the United States. The California Supreme Court decided against him last November.

* * *

Dr. Aims C. McGuinness, dean of the University of Pennsylvania Graduate School of Medicine, has been appointed clinical consultant for the 10 hospitals being constructed by the United Mine Workers Welfare and Retirement Fund.

* * *

U. S. Supreme Court has been asked to review a New York case in which the issue is: Does it constitute a rupture of the patient-doctor relationship for a hospital to disclose, upon official request, names and addresses of persons who have been patients of a certain physician? The case arose when internal revenue investigators requested from a hospital, the list of a doctor's patients admitted thereto.

* * *

Government marshals recently seized three "neuromicrometers" at the chiropractic hospital in Denver operated by Leo Spears. F. D. A. charged that the devices, shipped to Denver by a Utah firm, were used for diagnosis of cancer and tendency to cancer (and sundry other diseases) and charged that they are worthless for that purpose.

* * *

The Department of Health, Education, and Welfare has confirmed that Public Health Service research grants have been denied or withdrawn from 30 scientists since 1952 on the grounds of alleged subversion or disloyalty.

* * *

Federal-state responsibilities in the field of health will be studied by a special committee now being formed by the Commission on Intergovernmental Relations. The ten man group will include three Commission members. Formerly headed by Clarence Manion, the Commission now is under the direction of Meyer Kestnbaum, Chicago clothing manufacturer.

* * *

The Aero Medical Association has established the Louis Hopewell Bauer lectureship in honor of the association's first president. Dr. Bauer was president of the American Medical Association in 1952-1953 and is now secretary-general of the World Medical Association.

Veterans Administration has put into effect a new law, Public Law 311, that waives future physical examinations for veterans who have been rated totally and permanently disabled for 20 years or more.

* * *

Veterans Administration has informed a House Veterans Affairs subcommittee that over $6.8 million was spent on sites for the 16 V. A. hospitals that were canceled five years ago. Disposal of 15 of the sites has been authorized, including the one located in Toledo.

* * *

Gamma Globulin, as an anti-poliomyelitis weapon, in greater supply this year, is being allocated among the states by the Public Health Service on following basis: Forty-five per cent of supply earmarked in proportion to the total number of cases in the five year period 1949-53; Forty-five per cent to be apportioned by a formula which considers past incidence among children and participation in vaccine field trials; and ten per cent in a contingency reserve.

* * *

By a 6-3 decision the U. S. Supreme Court has upheld a six-month suspension of the license of a New York physician by the official New York State licensing agency. The doctor involved was convicted for contempt of Congress in refusing to give the House Committee on Un-American Activities information concerning an organization which he served as national chairman.

* * *

Data from the Office of Vital Statistics show that the number of reported cases of infectious hepatitis in the first quarter of 1954 was more than double the total for the comparable period last year. The respective totals are 17,120 and 8,216.

* * *

Federal Food and Drug Administration discloses that injunctions have been issued to bar shipment of products marked as "Garlex," and "No-Fast." The first, a liquid garlic compound was represented as treatment for tuberculosis, hypertension, colitis, typhoid, etc. The other, according to F. D. A., is a yellow ointment of petrolatum, salt, honey, and antiacids promoted as self-medication for stomach and duodenal ulcers.

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Intensive full time instruction covering those subjects which are of particular interest to the physician in general practice. Fundamentals of the various medical and surgical specialties designed as a practical review of established procedures and recent advances in medicine and surgery. Subjects related to general medicine are covered and the surgical departments participate in giving fundamental instruction in their specialties. Pathology and radiology are included. The class is expected to attend departmental and general conferences.

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A full time course. In Obstetrics: Lectures; pre-natal clinics; witnessing normal and operative deliveries; operative obstetrics (manikin). In Gynecology: Lectures; touch clinics; witnessing operations; examination of patients pre-operatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology. Anesthesia. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

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d. REGIONAL ANATOMY for those interested in preparing for Subspecialty Board Examinations.

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"Azopyrine* ... has been effective in controlling the disease in approximately two-thirds of patients who had previously failed to respond to standard colitis therapy currently in use."

1. Rev. Gastroenterology 20:744 (Oct.) 1953; abstract in J. A. M. A., 153:1580 (Dec. 26) 1953.

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Proposal of "A Family Doctor for Doctor's Family" Studied

The American Academy of General Practice is enlisting the support of the American Medical Association and other medical organizations in a project which is being given high priority support during 1954. The project is best described by the slogan, "A Family Doctor For Every Doctor's Family."

The academy undertook the project because it felt that, like the cobbler's children who have no shoes, the doctor's family may be getting the poorest medical care and attention.

The idea first was formulated by Dr. Merrill Shaw, academy vice-president, who has been critically ill at his home in Seattle.

In outlining the idea to the academy's board of directors, Dr. Shaw said he was convinced that physicians and their families receive "hopscotch" medical attention, neglect their own health, and seldom have a thorough check-up. He said that during his 20 years as a general practitioner, he does not recall that a single doctor ever came to him for a physical examination. Dr. Shaw provided records to show that the country is losing many highly trained doctors at the peak of their careers. Many of the deaths are due to preventable illness. He estimated that more than half the doctors in private practice work 60 or more hours a week. Their failure to practice what they preach may result in many premature deaths.

The academy presently is leading a campaign, especially among women's auxiliaries of state and county medical societies, to have every physician arrange for the services of a family doctor for himself and his family.

Fort Steuben Academy Holds Monthly Meetings

The Fort Steuben Academy of Medicine met at the Fort Steuben Hotel, Steubenville, on February 9, for a discussion of the subject, "The Surgical Aspects of Heart Disease." Speakers included, Dr. Harold Feil, clinical professor of medicine, Western Reserve University, Cleveland; Dr. William B. Ford, instructor in Thoracic surgery, University of Pittsburgh; Dr. Frank J. Gregg, assistant professor of medicine, University of Pittsburgh and assistant director of the Pittsburgh Diagnostic Clinic. Chairman of floor discussion was Dr. H. R. Sauder, Wheeling, W. Va.

The Academy held its next meeting on March 9 in the Fort Steuben Hotel, Steubenville. The subject was "Present Concept in the Management of Gastric Tumors." Guest speakers were Dr. George T. Pack, clinical professor of surgery, New York Medical College, and attending surgeon, Memorial Cancer Center; and Dr. J. E. McClenahan, associate professor of surgery, University of Pittsburgh. Chairman of floor discussion was Dr. Albert E. Winston, of Steubenville.



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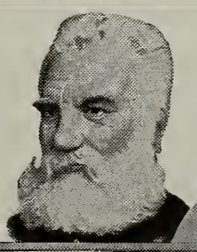
Only **audivox** in the hearing aid field can trace an ancestry that includes both Western Electric and Bell Telephone Laboratories. **audivox** lineage springs from the pioneer experiments of Dr. Alexander Graham Bell, which were furthered by the development of the hearing aid at Bell Telephone Laboratories, and in turn, brought to fruition by Western Electric and **audivox** engineers.

Distinctly a blueblood in its field, **audivox**, successor to Western Electric Hearing Aid Division, brings the boon of better hearing, and its enrichment of living, to thousands. With the magical modern transistor, with scientific hearing measurement and scientific instrument-fitting, serviced by a nationwide network of professionally-skilled dealers, **audivox** moves forward today in a proud tradition.

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In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

PHYSICIANS AND CIVIC AFFAIRS

Physicians who take part in civic activities often may wonder whether the time they spend is worth the effort. If so, they should dismiss that question from their minds promptly. They not only are doing themselves and the medical profession a real service, but more important yet, they are making vital contributions to their community and fellow citizens. If you don't believe this, read the following editorial from the *Akron Beacon-Journal* which proves the point:

"A prescription for his fellow doctors was given by Dr. Paul A. Davis of Akron, president of the Ohio Medical Association, at a convention in Columbus this week.

"Stop being doctors 24 hours a day and take part in other activities, was Dr. Davis' advice to his colleagues.

"Judging from the doctors we know, the exceptions to Dr. Davis' rule prove his point.

"What Dr. Davis had in mind was that when doctors take a hand in community affairs they build better relations between the public and their profession. We'll go along with that. However, what we meant when we said the exceptions to his rule prove his point is that the Akron doctors who DO participate in civic affairs are among the city's most useful citizens.

"As members of social agency boards and committtees and as officers in civic organizations they typically contribute keen judgment and progressive ideas. In the process of serving the community they also build good will for their profession, but that doesn't appear to be their primary goal."

In our opinion, physicians who sense their obligation to their community and do something about it are, as the *Beacon-Journal* says, "most useful citizens." It would be gratifying if more physicians would follow suit.

PROPER LIAISON WITH LEGAL PROFESSION

Noticed an item the other day about a meeting down in Nashville, Tenn., of a committee of the medical society and a committee of the bar association to discuss mutual problems.

Representatives of the Bar Association stated that the problems from their point of view lay generally in four categories: (1) The unwillingness of some physicians to testify in court, (2) Failure of some physicians to provide attorneys with medical reports, (3) Giving medical reports to unauthorized persons, and (4) Charging excessive fees for depositions and court attendance.

Members of the medical group, after being assured that the above complaints were not placed against doctors generally, explained some of the reasons for what might be regarded as unconcern by physicians. These were: (1) Some physicians are scared to death of courts and attorneys," (2) Opposing counsel tries to secure unauthorized reports, (3) Loss of professional time in court attendance often exceeds attendance fees many times over, and (4) Some physicians just don't have clerical personnel available for prompt reports.

In our opinion, much good could be derived by doctors and attorneys in any county from a meeting like the one described above. It's always helpful to get the other fellow's point of view. Nine times out of ten solutions can be worked out and problems eliminated or minimized by sitting down and talking over grievances—imaginary or otherwise.

Moreover, lots of good could come out of joint meetings with speakers from other groups participating and by the exchange of articles in bulletins and magazines published by each organization. Progress is being made in some Ohio cities, notably Cleveland and Cincinnati. Think it over.

A SPECIAL MESSAGE FOR THOSE NOT BELONGING TO A. M. A.

Medical Economics says it surveyed a group of physicians who are not members of the American Medical Association to find out why. It came up with the following reasons to which we have added, in parenthesis, a rebuttal:

1. Medical society dues are too high. (Far be it from us to try to evaluate anyone's financial status. However, that sounds rather phony in this day when most any active physician has just about all the practice he can handle and a reasonably good income.)

2. There are no particular benefits to be enjoyed. (Anyone who says that is just uninformed. The A. M. A. offers multiple tangible benefits to individual physicians who will just take advantage of them. Moreover, it offers the intangible benefits of collective security and collective action in dealing with the national government and national groups of all times not only for the best interests of public health but for the best interests of the medical profession as a whole. Skeptics should get literature from the A. M. A. telling the story of the A. M. A.)

3. They dislike certain policies of the A. M. A. (It would be far better if they would stay in and

pitch; try to get the policies changed to their liking. By staying outside, they will accomplish a big nothing.)

4. Some who dropped out when dues were first assessed would like to rejoin but balk at paying back dues. (In the end, those who did not pay, indirectly received benefits of the A. M. A. organization and activities. Thousands did pay dues to keep the machinery going. What's fair for some would appear to be fair for all.)

5. Some say the A. M. A. is all for specialists. Others say it is all for general practitioners. (The answer is: The A. M. A. is for the entire medical profession—specialists and general practitioners alike. There is something for each physician to get from the A. M. A. if he simply goes after it.)

6. The A. M. A. is run by a small "clique." (Not only a ridiculous but an erroneous charge. True, as in most organizations, a relatively few are extremely active. But, the A. M. A. is fundamentally a pure democracy. Each member has a voice in its government. If some don't exercise that right, it's their own fault.)

7. Apathy. (Not a valid reason even though it is too prevalent in most groups of business and professional people. Too many haven't learned the lesson that there is strength in numbers and in unity among members. Letting George do it has lost its popularity.)

This about covers the water front of the reasons offered. Actually, in most individual cases they are excuses, not reasons. There may be individual instances where the physician has a good reason for not belonging to the A. M. A. but our guess is that these are few and far between.

HOW ABOUT BECOMING ELECTION-MINDED NOW?

The first lap of the 1954 election derby was run on May 4. Now the entries in the November final heat are known. That is to say, their names are known. The big point now is: What do you know about the candidates for the many public offices to be filled?

That's where the Legislative Chairman, his committee and the officers of County Medical societies come into the picture. Their responsibility now is to get acquainted with the candidates; discuss medical-health questions with them; find out their attitude on medical matters. Later, this information should be passed on to all physicians of the community.

Now is the time when candidates are receptive to discussions. Now is the time for individual physicians to show interest in candidates. Waiting until after the election is like locking the barn door after . . . .

How about becoming election-minded right now?

CINCY ACADEMY ISSUES NEW NEWS SHEET

Congratulations to the Cincinnati Academy of Medicine for its new publication, "ACADOgram," a mimeographed news bulletin, issued periodically. It's a swell way to give members of the Academy brief notes on current and spot items of importance.

Of course, "OSMAgram" ought to sue for infringement but those Cincinnati doctors are real nice guys, so that's out. Anyway, maybe OSMAgram did a bit of larcency itself when it coined its own name. More power to you, ACADOgram.

ANY COMPLAINTS ON T. V. ADS IN YOUR AREA?

Any complaints about the medical and health advertising on the television programs being presented in your area? If so, send us the facts.

The Department of Public Relations of the American Medical Association has set up a very close liaison with the National Association of Radio and Television Broadcasters, the trade association of television broadcasting companies. The N. A. R. T. B. has a Code which it expects its members to live up to.

Violations of that Code by networks will be taken up by the A. M. A. Public Relations Department with the N. A. R. T. B. We'll send your complaints to the A. M. A.

Here are two sections of the N. A. R. T. B. Code of special interest to the medical profession:

"**Advertising of Medical Products:** The advertising of medical products presents considerations of intimate and far-reaching importance to the consumer, and the following principles and procedures should apply in the advertising thereof:

"(a) A television broadcaster should not accept advertising material which in his opinion offensively describes or dramatizes distress or morbid situations involving ailments, by spoken word, sound or visual effects.

"(b) Because of the personal nature of the advertising of medical products, claims that a product will effect a cure and the indiscriminate use of such words as "safe," "without risk," "harmless," or terms of similar meaning should not be accepted in the advertising of medical products on television."

"**Dramatized Appeals and Advertising:** Appeals to help fictitious characters in television programs by purchasing the advertiser's product or service or sending for a premium, should not be permitted, and such fictitious characters should not be introduced into the advertising message for such purposes. When dramatized advertising material involves statements by doctors, dentists, nurses or other professional people, the material should be presented by members of such profession reciting actual experience or it should be made apparent from the presentation itself that the portrayal is dramatized."

If your local broadcaster is violating these sections, discuss the matter with him.

The Wendt-Bristol Company

Now Three Complete Ethical Stores

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COLUMBUS, OHIO

for the convenience of the Physicians and Surgeons—and the many people they serve

Three Prescription Departments

maintained in a high class manner with large staff of registered Pharmacists

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JOBBING STOCKS ALL LEADING MANUFACTURERS

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Prompt Service on Phone Orders

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AND THE GERIATRIC DIET

Because of its ease of digestion, and its easiness on dentures, as well as the appetizing dishes which can be prepared from it, Knox Gelatine has marked patient acceptance in the geriatric diet.

Knox Concentrated Gelatine Drink is an accepted method of administering concentrated gelatine proteins wherever indicated.

YOU ARE INVITED *to send for the Knox Gelatine brochure on the geriatric diet. Write Knox Gelatine, Johnstown, N.Y. Dept. OS-6*

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ALL PROTEIN . . . . . NO SUGAR

AVAILABLE AT GROCERY STORES IN 4-ENVELOPE FAMILY SIZE AND 32-ENVELOPE ECONOMY SIZE PACKAGES.

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Unsurpassed among sulfa drugs for
Wide Spectrum—Highest blood levels—Safety—Palatability
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Prescribe or Dispense Buffonamide Today

Its tasty, cherry flavor appeals to all age groups

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Sulfacetamide . . . . . 0.166 gm	Sulfamerazine . . . . . 0.166 gm.
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You and Your Public . . .

Patient's-Eye View of Doctor Presented by Educator-Lecturer Gives Some Food for Thought that Physicians Would Do Well To Mull Over

A "PATIENT'S-EYE VIEW" of the doctor-patient relationship appeared in the March issue of the *Mahoning County Medical Society Bulletin.*

Entitled "The Patient Examines the Doctor" the article points out that, "while the doctor is looking for something wrong with the patient, the patient is looking for something right with the doctor." When both find what they are looking for, "a happy professional relationship at a friendly level should bring optimum results."

The article, a guest editorial, was written by Howard C. Aley, Youngstown, a member of the faculty of Woodrow Wilson High School, author, lecturer, and the central figure of a weekly television program in that city.

TWO-WAY EXAMINATION

Mr. Aley comments that while the physician is searching with scientifically perfected devices for evidences of malfunction or disease in the hope that with the wonders of science at his command, he can improve the patient's condition, the patient is looking over his physician.

The patient, he said, is examining his physician with less scientifically valid instruments but nevertheless highly significant emotional equipment, looking for evidences of humane qualities that will elevate the physician above the level of a scientific machine, and will strengthen the patient's confidence in his physician and in himself.

"PATIENT, WHAT OF THE DOCTOR?"

The author asks the question, "What does the patient hope to find in his doctor?" Here are some of his answers:

1. ". . . It may be fairly assumed that the patient has every right to expect a warm friendliness on the part of his physician even though the latter may have grave misgivings concerning the danger of coddling or babying his patients."

2. Even if the physician discovers that he is dealing with an immature personality, he should be willing to make some effort to reach the patient's emotional level.

3. ". . . The doctor would be the first to admit that the patient has every right to be treated as a human being, not looked over with the disdain of an automobile dealer viewing an old model in an off-season for trade."

THE EXTRA SOMETHING—THE HUMAN TOUCH

4. ". . . The old 'country doctor' idea insofar as doctor-patient relationships are concerned, seems to be the kind of relationship that most people think of as a desirable one." . . . "This is not to say that these qualities are not in evidence today; it is only to say that they are the qualities patients seek in addition to the specialized skills of modern doctors."

5. "The patient in examining his physician looks for simple statements concerning the nature of the treatment that has been prescribed. He usually prefers, too, to have some indication from the doctor as to what lies ahead."

"The oft-repeated statement 'The doctors won't tell you anything,' may justify a reconsideration of this practice. . . . Surely, the last thing the doctor would want to do would be to add to the patient's difficulties by frightening him. Yet a grave, non-commital attitude is to the patient most disturbing, for it may stimulate the patient's imagination to deplorable heights."

SAME SOLUTION—NEW APPLICATION

Mr. Aley concluded that it is one of the great satisfactions of life to be examined by a physician and pronounced whole. The good physician, he said, undoubtedly finds an equal satisfaction in having won the respect and admiration of those who have entrusted their health, if not their very lives, to him.

"In all of this," the author remarks, "there is certainly nothing new, but it is possible that in the doctor-patient relationships, as in so many other areas of living, the problem is not one of finding a new solution, but rather of applying the solutions we already have at hand. . . . It is encouraging to find that we have at times done better than we know. . . . It is never good to have known better than we did."

Medical Library Association To Meet in Washington

The Medical Library Association will hold its fifty-third Annual Meeting June 15-18, in Washington, D. C. The headquarters will be the Hotel Statler, and the official host the Armed Forces Medical Library.

Further information can be obtained from Lt. Col. Frank B. Rogers, Armed Forces Medical Library, 7th Street and Independence Avenue, S. W., Washington 25, D. C.

Washington headquarters of the American Psychiatric Association announces that it has formed a committee to certify physicians as "qualified mental hospital administrators."

In Memoriam . . .

Wilmer David Abrams, M. D., Mansfield; University of Pennsylvania School of Medicine, 1919; aged 62; died April 21; member of the Ohio State Medical Association, and the American Medical Association; treasurer of the Richland County Medical Society, 1933. Dr. Abrams had practiced in Mansfield from 1924 to the time of death. He was a member of the Alumni Association of the Mayo Foundation, having worked there for some three years under a fellowship in surgery. He was a member of several Masonic bodies, Kappa Alpha Phi, Beta Pi, the Congregational Church, Our Club, the American Legion. A daughter and a sister survive.

Charles Clark Beale, M. D., Mt. Sterling; Ohio State University College of Medicine, 1929; aged 51; died April 11; former member of the Ohio State Medical Association. Dr. Beale practiced for a while in Columbus before moving to Mt. Sterling a number of years ago. His mother survives.

Frank S. Cross, M. D., Lansing, Mich., Ohio State University College of Medicine, 1936; aged 54; died March 30; diplomate of the American Board of Pediatrics and member of the American Academy of Pediatrics. His widow, a sister and a brother survive.

William Harry Hull, M. D., Elyria; Medical College of Cincinnati, 1908; aged 69; died April 10; member of the Ohio State Medical Association, and the American Medical Association. A practicing physician in Elyria from 1914, Dr. Hull was active for a number of years in the Gates Hospital for Crippled Children. He was an examining physician for Selective Service during both World Wars, and was one of the founders of the former Elyria Clinic. He was a member of Nu Sigma Nu and Phi Delta Theta, several Masonic bodies, the Lutheran Church, Elyria Country Club. His widow and a son survive.

Wilmer G. Lane, M. D., Cambridge; Columbus Medical College, 1889; aged 90; died April 5; member of the Ohio State Medical Association through 1947. Dr. Lane retired in 1947 after practicing some 58 years in the Otsego and Bloomfield communities of Muskingum County and in Cambridge. His father, the late Dr. L. M. Lane, was a practicing physician in that area before him. He was a member of the Rotary Club and the United Presbyterian Church. Surving are three daughters.

William J. Manning, M. D., Cleveland; Western Reserve University School of Medicine, 1902; aged 75; died April 20; former member of the Ohio State Medical Association. Dr. Manning began his practice in Cleveland upon completion of his education and practiced there until his retirement a few years ago. He had received the 50-Year Pin of the Ohio State Medical Association. He was for many years on the staff of St. John's Hospital and served as attending physician at several Catholic institutions. Surviving are his widow, two daughters, two sons, two brothers and three sisters.

John E. Maska, M. D., Cleveland; University of Wooster, Medical College, Cleveland, 1901; aged 77; died April 27; member of the Ohio State Medical Association; member of the American Medical Association. A practicing physician in Cleveland since completion of his medical training, Dr. Maska had received the 50-Year Pin of the Ohio State Medical Association. For nearly 30 years, he was physician for the Lamson & Sessions Co. and other industrial firms. Survivors include a brother and two sisters.

Charles Bradfield Morrey, M. D., Columbus; Starling Medical College, Columbus, 1896; aged 84; died April 21. Dr. Morrey was professor emeritus and former chairman of the Department of Bacteriology at Ohio State University. He was a member of the Society of American Bacteriology, the American Chemical Society, the American Association for the Advancement of Science. Surviving are his widow, two daughters, and a son.

Louis E. Payne, M. D., Toledo; Johns Hopkins University School of Medicine, 1917; aged 63; died April 15; member of the Ohio State Medical Association and former member of the American Medical Association; diplomate of the American Board of Pediatrics. Dr. Payne was a veteran of World War I, having gone into service upon receiving his M. D. degree. He began practice in Toledo after doing postgraduate work in the east. Dr. Payne was director of pediatrics at Mercy Hospital and was a member of the staffs of Toledo and St. Vincent's Hospitals. Surviving are his widow, a daughter and a brother.

James Douglas Pilcher, M. D., Cleveland Heights; Western Reserve University School of Medicine, 1905; aged 74; died May 4; member of the Ohio State Medical Association through 1950; member of the American Pediatric Society. From 1905 to 1914, Dr. Pilcher taught pharmacology at Western Reserve and then went to the University of Nebraska where he taught the same subject. He served in the U. S. Medical Corps during World War I, during which he attained the rank of Major. Following the war, he returned to Western Reserve where he retired as associate professor of pediatrics in 1950. Sur-

viving are his widow, Dr. Jean Pilcher, and three sons.

John Edward Rauschkolb, M. D., Shaker Heights, Cleveland; Western Reserve University School of Medicine, 1923; aged 58; died April 28; member of the Ohio State Medical Association; member of the American Medical Association; diplomate of the American Board of Dermatology and Syphilology; member of the American Dermatological Association and fellow of the American College of Physicians; past-president of the Cleveland Academy and former member of its Board of Directors; former delegate of that Society to the Ohio State Medical Association; also active on several local committees. Dr. Rauschkolb served with the National Guard on the Mexican Border and later with the Army in Europe during World War I. He was a member of numerous organizations including the Optimist Club, several Masonic bodies, the Cleveland Skating Club, the City Club and others. Surviving are his widow, two daughters and a sister.

Raymond Alward Rogers, M. D., Columbus; Ohio State University College of Medicine, 1920; aged 65; member of the Ohio State Medical Association and the American Medical Association; member of the Ohio Academy of General Practice. Dr. Rogers practiced medicine in Columbus for 33 years. He was a member of the Methodist Church and the Masonic Lodge. Surviving are his widow and a brother.

Charles Francis Shiveley, M. D., Cambridge; Ohio State University College of Medicine, 1916; aged 60; died April 21; member of the Ohio State Medical Association and the American Medical Association. Upon completion of his internship, Dr. Shiveley went into service with the Army during World War I. After release from the Army, he opened a practice at Lore City, and moved to Cambridge in 1924 after doing postgraduate work at Harvard. In addition to his professional work, he was a member of the Christian Church, several Masonic bodies, the Rotary Club, Odd Fellows. Survivors include his widow, a daughter and a sister.

Ralph W. Stewart, M. D., Toledo; Jefferson Medical Colege, 1902; aged 78; died January 11; member of the Ohio State Medical Association; member of the American Medical Association; recipient of the 50-Year Pin of the Ohio State Medical Association.

John William Wood, M. D., Mt. Gilead; Jefferson Medical College, Philadelphia, 1895; aged 84; died April 28 in a railroad crossing accident. A native of Morrow County and practitioner there for many years, Dr. Wood had retired about 25 years ago. A son and two sisters survive. Mrs. Wood died with her husband in the accident.

Claude Foster Yauman, M. D., Youngstown; Eclectic Medical College, Cincinnati, 1915; aged 66; died April 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Yauman moved to Campbell in the Youngstown area from Petersburg about 30 years ago, and had been a practicing physician there since. He was a member of Sigma Theta and the United Presbyterian Church. Survivors include his widow, a son and four daughters.

Health on The Radio Programs in Demand

Demand for A. M. A. radio transcriptions on common health subjects hit an all-time high during 1953. During the year more than 700 sets were distributed for broadcasting over local radio stations in all parts of the country.

Assisting the Bureau of Health Education in distributing these health education platters and promotional material are 14 distributing centers set up by 13 state medical societies and the Alaska Department of Health. The Pennsylvania Medical Society, for example, arranged 1,989 local programs in 1953 and the Louisiana State Medical Society 1,157.

One of the most popular series was "Heart of America," which presents 13 case reports from outstanding cardiologists. Other popular new series include: "Chats with the Champs," "Help Yourself to Health," "Yours for Health," and "June, July and August."

These transcriptions are provided without charge by the A. M. A. as a public service for medical societies and woman's auxiliaries. Universities and high schools, state and local departments of health, various voluntary health agencies and allied health organizations, such as heart and cancer societies, often request these transcriptions and sponsor them locally. Such requests always are cleared through the local medical society.

Report Surge of Requests For Placement Aid

More physicians are utilizing the services offered by the A. M. A. Physicians Placement Service than ever before, reports the Council on Medical Service. A brief look at the number of services rendered by the Placement Service during the last three months of 1953 as compared with the same period of 1952 shows: (1) A 95 per cent increase in the number of requests from communities seeking physicians; (2) A 130 per cent increase in the number of letters of inquiry from physicians seeking places to locate; (3) A 364 per cent increase in the number of physician visits and personal interviews in the A. M. A. office. This Service operates in close cooperation with the 43 state physician placement services.



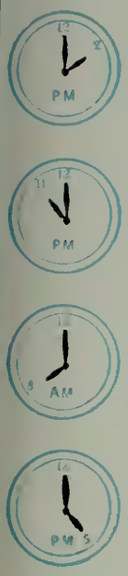
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Simple, dramatic proof of the effectiveness of Tetracyn is offered by the characteristic rapid defervescence noted in the treatment of a wide range of susceptible infectious diseases. *Think of Tetracyn* whenever you take a temperature for an AIH response in Tetracyn-sensitive infections.

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Rx



"... its use is followed by a rapid clinical response. Symptoms, including fever, largely cleared up within 24 to 48 hours."

English, A. R., et al.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.

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Brand of **tetracycline** hydrochloride

Tetracyn represents a nucleus of modern broad-spectrum antibiotic activity. With it you may expect

- *unexcelled tolerance*
- *outstanding stability*
- *high concentrations in body fluids*

Tetracyn may often be effective where resistance or sensitivity precludes other forms of antibiotic therapy.

TETRACYN TABLETS (*sugar coated*) 250 mg., 100 mg., 50 mg.

ASIC PHARMACEUTICALS FOR NEEDS BASIC TO MEDICINE

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D., MIDDLETOWN)

ADAMS

The Adams County Medical Society held its regular meeting April 22 in the Adams County Hospital, West Union. The meeting started at 11:00 a. m. and was followed by luncheon. For the scientific program Dr. Arthur Evans, Cincinnati, spoke on phases of urology, and Dr. Joseph Gohman, Mercy Hospital, Portsmouth, spoke on pathology.

BUTLER

A second $1,000 donation was made by the Butler County Medical Society to the American Medical Education Foundation, President J. A. Carter announced. A similar donation was made last year.

The meeting of the Society was held at the Eugene H. Hughes Memorial Hospital, in Hamilton on April 28, preceded by a social hour and dinner. A program on the subject, "Present Surgical and Medical Management of Tuberculosis," was presented by a team from the hospital consisting of Dr. J. N. Christiansen, medical director; Dr. Azel Ames, chief surgeon; and Dr. Louis Buente, consulting surgeon.

HAMILTON

Two features of the Academy of Medicine of Cincinnati program for May were the following:

A talk by Dr. Carl C. Pfeiffer, professor of pharmacology and head of the Department, University of Illinois College of Medicine, Chicago, on May 4, entitled "Untoward Reactions to Drugs."

A discussion on May 18, entitled "Dynamic Therapeutics in Chronic Disease," by Dr. Howard A. Rusk, professor and chairman of the Department of Physical Medicine and Rehabilitation, New York University College of Medicine.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

DARKE

The subject, "Cephalo-pelvic Disproportion," was discussed at the April 20 meeting of the Darke County Medical Society by Dr. H. E. McKnight, of Dayton. The dinner meeting was held in the Wiebusch Manor, Greenville.

The regular monthly meeting of the Society was held on May 18 with dinner at the Wiebusch Manor, Greenville. The speaker was Dr. Edward Gall of Dayton, whose subject was "Carcinoma of the Lung."—Maurice Kane, M. D., Secretary.

GREENE (FOUR COUNTIES)

The Greene County Medical Society was host to the four-county group comprising Greene, Fayette, Highland and Clinton County Medical Societies for a luncheon meeting in Xenia on May 12.

The scientific program was conducted by a team from the Department of Neurology and Neurosurgery, University of Cincinnati College of Medicine consisting of: Dr. Frank Espey, chairman, and Drs. Robert McLaurin and Samuel Trufant.

The following topics were discussed: "Diagnosis and Treatment of Spinal Cord Injuries," Dr. McLaurin; "Convulsions in Children," Dr. Trufant, and "Surgical Treatment of Intractable Pain—Secondary to Carcinoma," Dr. Espey.—P. F. McQuiggan, M. D., President.

MIAMI

A joint meeting of the Miami County Medical Society and Woman's Auxiliary was held May 6 in the Troy Country Club. The speaker was William Milligan, Jr., Sidney attorney, who discussed his experiences while spending the year 1952 in Uraguay. — Dale A. Hudson, M. D., Secretary.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

Following are features of the Academy of Medicine of Toledo program during May:

General Meeting, May 7—"When Medicine and the Law Meet," Wayne E. Stichter, Toledo attorney.

Section on General Practice, May 14—"Geriatrics," a panel discussion.

Medical Section, May 21—"Claims and Counterclaims in Hypertensive Disease," Dr. Arthur C. Corcoran, Research Division, Cleveland Clinic.

Surgical Section, May 28—"Medical and Surgical Aspects of GI-Diverticulum and Diverticulitis," a panel discussion.

The weekly color television programs by the American Cancer Society continued at the Academy headquarters building. The subjects were: "Lymphoma and Leukemia," "Tumors of Childhood," "Hormonal and Chemical Treatments of Cancer," and "Treatment of Patients with Advanced Cancer—Analgesia and Psychiatry."

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

SUMMIT

For its scientific program for April 6, the Summit County Medical Society presented Dr.

Walter J. Reich, professor of gynecology, Cook County Graduate School, whose subject was "The Diagnosis and Management of Common Gynecological Problems." The meeting was held in Knight Hall, University of Akron.

At the May 4 meeting of the Society, Clark C. Grubbs, assistant supervisor of claims, Industrial Commission of Ohio, discussed "How To Collect the Correct and Easy Way from the Industrial Commission." The dinner meeting was held in the City Hospital of Akron Nurses' Home. Office assistants of physicians also were present to hear the discussion.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

Dr. Arthur James, associate professor of surgery, Ohio State University, gave an illustrated talk on tumors of the neck at the April 22 meeting of the Belmont County Medical Society and Auxiliary.

TUSCARAWAS

Twenty-eight members and two guests were present at the meeting of the Tuscarawas County Medical Society on April 8 at Union Hospital Auditorium. The guests were Dr. C. J. Miller, Jr., and the speaker of the evening, Dr. Robert E. Brubaker, of Akron.

Dr. Brubaker gave an enlightening talk on "The Practical Aspects of Fluid and Electrolyte Balance."

It was reported that final statistics on the Diabetes Drive last fall reveal that 11,501 free tests were performed. Of 852 positive tests, 537 were followed up. In these there were 132 diabetics, 98 of whom were previously known and 34 were previously unknown or new cases. Twelve of the new cases were in the age group 5-24.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

"Management of Head Injuries" was the subject discussed by Dr. Harry LeFevre, Columbus, at the April 19 meeting of the Scioto County Medical Society. The meeting was held in the General Hospital Nurses Home.

At the May 10 meeting, Dr. Joseph Freiberg, professor of orthopedics, University of Cincinnati College of Medicine, spoke on "Diagnosis and Treatment of the Arthritides."

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

ROSS

The Ross County Academy of Medicine met on the evening of May 6 with President Holmes presiding. Twenty-seven members were in attendance and four guests, including the speaker.

Dr. William Corzine was voted into associate membership in the Academy. Dr. Edwin H. Artman, Tenth District Councilor, presented as a guest, Dr. Newman Dyer, new health officer for Ross, Pike and Fayette Counties.

A more efficient system to disseminate medical news to the Society in the form of a monthly mimeographed bulletin was proposed by the Council of the Academy and approved.

The Society voted to endorse the project of a Citizen's Emergency Truck Committee and to volunteer to instruct the operators of the truck and the inhalator in medical techniques of resuscitation. The president was authorized to appoint a committee for such purpose at the request of the Fire Department.

New business included the announcement of the organization of a Family Council. This Council is to be made up of clergymen, lawyers, physicians and other interested parties.

Dr. G. Howard Wood then introduced Dr. Damon E. Wetterauer who spoke to the Society on the general subject of tuberculosis.—Lewis W. Coppel, M. D., Secretary.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The regular monthly meeting of the Lorain County Medical Society was held on April 13 at the Spring Valley Country Club, Elyria, beginning with dinner. A business meeting was followed by a program at which two Cleveland physicians spoke.

Dr. Henry Zimmerman discussed "The Diagnosis and Indications for Cardiac Surgery"; while Dr. Earle B. Kay talked on "The Risk and Results of Cardiac Surgery."

MEDINA

At the February dinner meeting of the Medina County Medical Society, Dr. William Forsythe and Dr. William Weir, Jr., were guest speakers. From the genito-urinary and gynecological standpoints, respectively, they spoke on the "Clinical Aspects of Infertility." Their talks, illustrated by slides, were based upon the study of 550 cases in the Maternal Health Clinic of Cleveland.

Pauline Riegger, director of the Medina County Welfare Department, and Thelma Kaylor, manager of the Aid for the Aged office, met with the Society for an informal round-table conference at the March evening meeting.

The Medina County Society is happy to welcome one of its members as Councilor of the Eleventh District, Dr. H. T. Pease, Wadsworth.

Dr. Willard Allison, of Akron, brought two patients with him to the Society meeting at Wadsworth Hospital on April 15. He spoke on

the subject, "Diabetes Insipidus."—E. C. Whitacre, M. D., Secretary.

RICHLAND

Members of the Richland County Medical Society held a dinner meeting at the Mansfield General Hospital, April 29. Following dinner, a business meeting was conducted by the President, Dr. Russell H. Barnes, after which the program was presented.

Paul Martin, chief of police of the City of Mansfield, addressed the group on the subject of "Narcotics."—P. O. Staker, M. D., Secretary.

Markle Scholarship Awarded at University of Cincinnati

The John and Mary R. Markle Foundation, New York City, has awarded a $30,000 scholarship to Dr. Julius B. Kahn at the University of Cincinnati College of Medicine. The scholarship to extend over five years. Dr. Kahn is assistant professor of pharmacology.

Other Markle scholars at the College are Dr. William D. Lotspeich, who fills the Joseph Eichberg chair of physiology, and Dr. Harvey C. Knowles, Jr., assistant professor of medicine.

Activities of Woman's Auxiliary . . .

By MRS. FREDERICK W. JAMES, Chairman, Publicity Committee, 423 E. Allen St., Lancaster, Ohio

President—Mrs. A. Paul Hancuff, 3551 Maxwell Rd., Toledo, Ohio

President-Elect—Mrs. Karl Ritter, 1420 Shawnee Rd., Lima, Ohio

Vice-President—Mrs. Charles Obert, 20710 Park Cliff Drive, Fairview Park, Cleveland 26, Ohio

Recording Secretary—Mrs. S. L. Meltzer, 2442 Dorman Dr., Portsmouth, Ohio

Corresponding Secretary—Mrs. John Dickie, 2215 Parkwood Ave., Toledo, Ohio

Treasurer—Mrs. Herbert Van Epps, 435 E. 15th St., Dover, Ohio

Past President—Mrs. N. M. Reiff, 404 Rawlings St., Washington Court House, Ohio

A. M. E. F.

The following additional counties have contributed to the American Medical Education Foundation since the last report, according to Mrs. George W. Cooperrider, chairman; Belmont, Cuyahoga, Highland, Lucas, (second contribution), Montgomery, Mercer, Muskingum, Scioto and Wyandotte. "In Memoriam" contributions toward the same fund have been received from Champaign, Franklin, Greene, Montgomery and Washington Counties. Final report as of May 15, shows 54 out of 61 county auxiliaries have contributed a total of $2,869.00. Mrs. Cooperrider stated that there is still time to make Ohio 100 per cent.

ALLEN

Election of officers and an informative talk by Mrs. W. Clayton Lytle, Wilmington, Del., director of women's activities for Region 2, Federal Civil Defense Administration, high lighted the meeting held by the Auxiliary to the Lima and Allen County Academy of Medicine, March 23.

The following officers were elected for the 1954-55 season: Mrs. M. M. Sondheimer, president; Mrs. R. P. Epstein, vice-president; Mrs. J. W. Burke, president-elect; Mrs. R. G. Hendershot, secretary; and Mrs. D. L. Becker, treasurer.

Mrs. C. H. Zinsmeister, incumbent president, presided. Mrs. A. Barone, program chairman, introduced Mrs. Lytle, who outlined recent developments in federal civil defense and discussed the roles women could play in these activities.

CHAMPAIGN

Mrs. F. R. Grogan, chairman of the nominating committee, presented a slate of officers which was unanimously elected at the luncheon meeting of the Auxiliary to the Champaign County Medical Society, Tuesday, April 6, in Milner's Colonial room. The slate includes Mrs. I. Miller, president; Mrs. John Polsley, president-elect; Mrs. A. B. Reams, vice-president; Mrs. M. C. Houston, secretary-treasurer; and Mrs. V. G. Wolfe, historian. The business meeting was conducted by Mrs. F. E. Lowry, president.

CLARK

"Gardenia Day" was held in Springfield on March 20 when members of the Woman's Auxiliary to the Clark County Medical Society held their annual sale. The proceeds of this sale will finance scholarships for qualified girls interested in becoming nurses. Funds received in the past three years from this project have enabled the Auxiliary to assist in financing scholarships for two girls who have now become registered nurses, one student who is in her third year of training, one who is in her second year, and three who

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are in their first year. Mrs. Chas. E. Fralick served as general chairman of this year's sale.

DELAWARE

Dr. W. A. Manuel spoke on "Civil Defense in the Home" at the April meeting of the Delaware County Medical Auxiliary at the home of Mrs. E. C. Jenkins. Assistant hostesses were Mrs. George Blydenburgh and Mrs. A. R. Callander. Mrs. E. J. Marsh, the tenth District Director, was a guest.

FAIRFIELD

Mrs. C. P. Swett, Mrs. A. B. VanGundy, Mrs. E. H. Hamilton and Mrs. Wm. Monger were hostesses for the Annual Guest Day of the Woman's Auxiliary to the Fairfield County Medical Society, April 6, at the Country Club. Dr. Dwight Palmer, Columbus, spoke on "Tobacco and Its Relation to Medicine."

Mrs. Frederick Spangler conducted a brief business session. She announced that Mrs. Frederick James had been elected State Publicity Chairman.

FRANKLIN

The Auxiliary to the Ohio State Medical Association held its annual convention in Columbus April 13, 14 and 15, with members of the Auxiliary to the Columbus Academy of Medicine as hostesses.

Mrs. N. M. Reiff of Washington Court House, state president, presided at the business sessions. Mrs. Harvey M. Clodfelter, Bryden Rd., president of the Columbus chapter, welcomed the visitors. Mrs. Charles Harding, Olentangy River Rd., was chairman of the Tuesday luncheon; Mrs. Robert H. Schoene, Brookside Dr., chairman of the Wednesday luncheon; and Mrs. Phillip Knies, Columbia Ave. arranged the special program for Thursday. One of the highlights of the meeting was the Tea at the Governor's Mansion.

Three Columbus women were named to posts in the Woman's Auxiliary to the Ohio State Medical Association. Mrs. George W. Cooperrider was elected to the board of directors; Mrs. A. L. Kefauver will serve as chairman to Civil Defense, and Mrs. Rivingston Fisher was named to the editorial staff of the *Auxiliary News*.

At the April meeting of the Woman's Auxiliary to the Columbus Academy of Medicine, Dr. James E. Pollard, director of the school of journalism at Ohio State University, was the speaker. Arrangements were made for the program by Mrs. Miner Seymour.

HAMILTON

The Woman's Auxiliary to the Hamilton County Medical Society met March 16 at the Hotel Gibson in Cincinnati. Mrs. Robt. H. Kotte, president, conducted an important business meeting.

The speaker of the day, Mr. Kenneth Kurt, of the Minnesota Mining and Manufacturing Co.,

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At the April meeting of the Auxiliary, Mrs. Howard L. Stitt was the speaker, her topic "Music and Ancient Therapy."

HURON

The March meeting of the Woman's Auxiliary to the Huron County Medical Society was held at the home of Mrs. Frederick B. Western, New London, for 1:00 o'clock dessert. Mrs. Western was assisted by Mrs. Mary Roasberry. Mrs. T. H. Smith, president, conducted the business meeting. Dr. and Mrs. Western showed films and told the guests about their recent trip to Europe.

LUCAS

The general membership meeting of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County met March 9 in the Academy of Medicine Bldg. Mrs. Norman B. Muhme, introduced Mrs. Mary Rowe of the J. F. Bennett Studio who gave a talk and demonstration on "Interior Decorating."

The terms "nursing" and "shortage" have become as closely associated as "thermometer" and "temperature." The nation's nursing shortage is severe and chronic and doctors' wives have this problem ever in mind. The Woman's Auxiliary to the Toledo Academy of Medicine recently sponsored formation of an FNC city-wide council and offered to do its part in promoting a statewide organization.

Wives of doctors who attended the Northern Tri-State Medical Association meeting April 1 were entertained by the local Auxiliary. The program included a coffee and doughnut hour, a visit to the Toledo Museum and a luncheon and style show. The committee in charge of arrangements included: Mrs. Bernhard Steinberg, Mrs. Wm. Mewborn, Mrs. David Katchka, and Mrs. Boni E. Petcoff.

MAHONING

Over 125 Mahoning County high school girls interested in making nursing their career, were entertained at a tea in March at the St. Elizabeth Hospital, with members of the Woman's Auxiliary to the Mahoning County Medical Society as hostesses. Featuring the program in charge of Mrs. W. E. Maine, was a talk and demonstration of Braille by Dr. Pauline Powers, teacher of the blind at Chaney High School.

Fifty members, wives of Mahoning County doctors attended the April meeting of the Auxiliary at the Woman's City Club. Mrs. Rosenblum introduced the speaker of the day, Mrs. Arthur Struble whose topic was civil defense. During the business session, a slate of officers was presented, Mrs. Ivan C. Smith, Youngstown, being elected president.

MIAMI

Installation of 1954-55 officers and an address on Civil Defense were features of the April meet-

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ing of the Woman's Auxiliary, Miami County Medical Society, at Tipp City with Mrs. Maynard C. Kiser as hostess. Mrs. Joseph E. Bausman of Piqua, president; Mrs. Burton E. Hyde of Troy, president-elect; Mrs. E. G. Puterbaugh, Tipp City, vice-president; Mrs. R. A. Reich of Troy, secretary; and Mrs. C. E. Stout of West Milton, treasurer.

MONTGOMERY

The Woman's Auxiliary to the Montgomery County Medical Society held their regular monthly meeting at Sutmiller's on April 20. Mr. Robert Freeman, Executive Secretary of the Medical Society, spoke to the group on "The Role of the Auxiliary and Medical Society in Local Health Problems." Mrs. Darrell Caudill was chairman of the day.

RICHLAND

The April meeting of the Woman's Auxiliary to the Richland County Medical Society was held at the Women's Club with Mrs. P. A. Blackstone presiding. Mrs. Karl Kuehne presented a paper on "Health Agencies in Richland County."

New officers were elected for the coming year, They are as follows: Mrs. Robert Crawford, president; Mrs. Robert Pierce, president-elect; Mrs. F. M. Wadsworth, vice-president; Mrs. Paul Lee, treasurer; Mrs. H. S. Wiedemer, recording secretary; and Mrs. L. A. Hautzenroeder, corresponding secretary.

"Know Your Community" has been the objective of the Woman's Auxiliary to the Richland County Medical Society this year. Monthly programs have concerned Kingwood, Mansfield's cultural center; civil defense, the nursing situation, registered and practical; and health education as presented by the chief of the Ohio Department of Health in Richland County.

SANDUSKY

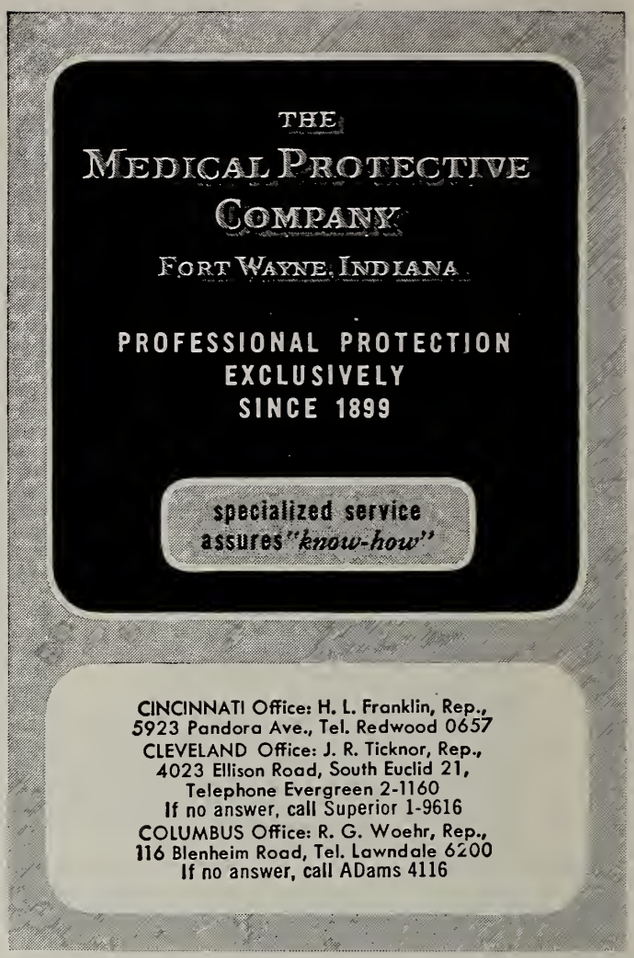
Mrs. W. J. Martin was hostess for the Woman's Auxiliary to the Sandusky County Medical Society March 16, with Mrs. C. I. Kuntz and Mrs. J. W. Monahan assisting. The president, Mrs. Allen Newman, conducted the meeting.

Mrs. Russell Hull gave an outstanding book review on "To Heaven on Horseback."

TRUMBULL

The Trumbull County Medical Auxiliary held a recent guest day luncheon at the Squaw Creek Country Club. Miss Geraldine Ralston and Miss Diana Babinchak, student nurses at Trumbull Memorial Hospital were presented as last year's winners of the essay contest, "Why I Want To Be a Nurse." This contest is open to all high school seniors.

After a short business meeting, guests were introduced and the speaker was presented. Mrs. J. Elmer Smith of Youngstown gave an illus-



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trated lecture on ways to be beautifully dressed on prices one can afford.

A joint meeting of the Trumbull County Medical Society and the Auxiliary was held late in April at the Trumbull Country Club. Dr. Grayson Carroll of St. Louis, Mo., international authority on antibiotic and chemotherapeutic drugs in urology, was the guest speaker.

Money has been donated by the Auxiliary for the purchase of the Warren Auditory Unit to be used in schools throughout the county. This Unit will be a great help to the children afflicted with loss of hearing and speech defects.

Points Out Dangers of Tinted Glass For Night Driving

Use of tinted glass in automobiles or the wearing of colored glasses for night driving is dangerous because it causes decreased visual efficiency, in the opinion of Dr. Paul W. Miles, St. Louis.

"Particularly unfortunate is the popular selection of pink for the glasses and acquamarine green for the windshields," Dr. Miles wrote in a recent issue of *Archives of Ophthalmology*, published by the American Medical Association. "While pure red and pure green filters may be quite transparent, in combination they are opaque."

"Modern windshields were made green because large areas of glass let in too much heat from the sun. A green filter cuts out the red and infrared rays which carry heat. For purposes of night driving this windshield color becomes the worst possible selection, because automobile headlight is unbalanced. Almost two-thirds of headlight energy is concentrated in the red end of the spectrum, and only one-third is in the range to which a green windshield is most transparent."

Dr. Miles pointed out that tests have shown that visual acuity is markedly decreased by the use of tinted glass for night driving. Normal vision is 20/20. During night driving visual acuity is 20/32 through colorless glass, 20/34 through light yellow glass, 20/40 through pink glass, 20/46 through green windshield glass, and 20/60 through the combination of pink glasses and a green windshield.

"Green windshield glass should be in a separate layer, to be moved aside for night driving. Persons with defective vision, including color blindness of the common type, should be advised to add auxiliary headlights to their automobiles and to avoid any type of tinted glass for night driving."

Dr. Miles is associated with the department of ophthalmology and the Oscar Johnson Institute of the Washington University School of Medicine.

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GYNECOLOGY—Office & Operative Gynecology, Two Weeks, September 20. Vaginal Approach to Pelvic Surgery, One Week, June 21.

MEDICINE—Two-Week Course, September 27. Electrocardiology & Heart Disease, Two Weeks, July 12. Gastroenterology, Two Weeks, October 25.

RADIOLOGY—Diagnostic Course, Two Weeks, October 4. Clinical Course, Two Weeks, by appointment. Radiation Therapy, by appointment.

PEDIATRICS—Clinical Course, Two Weeks by appointment. Congenital & Rheumatic Heart Disease in Infants & Children, One Week, October 11 and October 18, Two Weeks, October 11.

UROLOGY—Two-Week Urology Course, September 20. Ten-Day Practical Course in Cystoscopy every two weeks.

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Ohio Rural Traffic Accidents Show Small Increase in 1953

The Ohio Department of Highway Safety issued the following information in regard to traffic accidents on state highways outside of municipalities for 1953:

Traffic deaths on state highways outside municipalities totaled 991 in 1953, an increase of two per cent over the 972 deaths reported in 1952 traffic accidents. The 991 deaths on rural state roads will account for about half of the statewide traffic death toll estimated to be 2,014 for 1953.

The 1953 death rate per 100,000,000 miles of travel on rural state highways was 9.6 as compared to 9.9 for 1952, a decrease of 3 per cent.

Collisions of motor vehicles accounted for 553 deaths on rural state highways. These deaths made up 56 per cent of the death toll on rural state roads.

Pedestrians killed in rural accidents during 1953 numbered 105 as compared to 107 deaths in 1952.

In 1953, deaths in non-collision accidents on rural state highways numbered 272 as compared to 307 deaths in this type of accident in 1952, a decrease of 11 per cent.

In 1953, Summit County led the state with 39 deaths in traffic accidents on rural state highways. Other counties with high death tolls on rural state roads were: Butler, 35 deaths; Portage, 33 deaths; Trumbull, 32 deaths.

Persons injured in 1953 traffic accidents numbered 18,299, an increase of six per cent over the 17,345 injuries in rural highway accidents during 1952.

In 1953 on rural state highways, one fatal accident was reported in which seven persons were killed. Other multiple-death accidents during 1953 were as follows: One accident with 6 deaths; 3 accidents, 5 deaths each; 7 accidents, 4 deaths each; 35 accidents, 3 deaths each; 90 accidents, each with 2 deaths.

The record number of injuries in any one accident during 1953 was 15; another accident resulted in 14 injuries.

There were 31,002 traffic accidents reported on rural roads in 1953, exceeding the previous high of 27,683 accidents in 1952, an increase of 12 per cent.

Traffic accidents reported on rural state highways were above the thousand mark in four counties: Lucas, 1265 accidents; Trumbull, 1,086 accidents; Summit, 1,054 accidents; and Montgomery, 1,026 accidents.

A handy new pocket-size speaker's kit providing the basis for running commentary on a series of 17 color film strips on veterans medical care now is available from the American Medical Association for showings at state and county medical society meetings.

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WOMAN*

The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Making and Keeping Friends, by William C. Menninger, M. D., ($0.40. *Science Research Associates, Inc., 57 W. Grand Ave., Chicago 10, Ill.).* A life adjustment booklet designed by this eminent authority to help young people solve one of their major problems.

It's Not All in Your Mind, by H. J. Berglund, M.D., and H. L. Nichols, Jr. ($3.95. *North Castle Books, Greenwich, Conn.*). The author has had good training in both allergy and psychiatry. She recognizes that psychosomatic disease does exist, but that it is present only in a small portion of the cases reported. It will put every physician and nervous patient in a better perspective towards their problems. In this day of over-emphasis upon psychosomatic medicine, this book should have wide reading.

The Pathology of Trauma, by Alan Richards Moritz, M.D. ($8.50. Second Edition. *Lea & Febiger, Philadelphia 6, Pa.*). An important book for anyone dealing with injuries and the adjustment of claims arising therefrom. Its chapter on the medico-legal autopsy in its present form is a classic and well worth the price of the book.

Adventures with The Inner Voice: Spiritual Essays and Poems, by B. J. Manoogian, M.D. ($3.00. *Exposition Press, New York 10, N.Y.*). The result of many years of meditation. These words of wisdom are set forth by the author for you and me to read a little at a time to help us to follow our own "inner voice."

Adaptation in Micro-Organisms, Edited by E. F. Gale, and R. Davies ($6.00. *Cambridge University Press, American Branch, New York 22, N.Y.*). Being the Third Symposium of The Society for General Microbiology. Micro-organisms are found in a wider range of environmental conditions than are higher organisms and often may be subject to very rapid change; consequently to survive they must show great adaptability. Thus they offer excellent experimental material for the study of the nature and mechanism of adaptation. This symposium has been written by some of the foremost authorities and deals with the subject at the top level.

An Introduction to Human Biochemical Genetics, by H. Harris, M.D. ($2.75. Published for: *Galton Laboratory, University College, London, England by Cambridge University Press, New York 22, N.Y.*). The scientific study of inborn biochemical peculiarities was first made by Sir A. E. Garrod in his work with alkaptonuria. He demonstrated that this peculiar biochemical trait was caused by the presence of a single hereditary unit. Here we find a summary of cystinuria, methaemoglobinaemia, tyrosinosis, fructosuria, glycogen disease, phenylketonuria, renal glycosuria, sick cells, blood group substances, and several other conditions.

Child Training and Personality—A Cross-Cultural Study, by John Wesley M. Whiting, and Irvin Long Child ($5.00. *Yale University Press, New Haven, Conn.*). Seventy-five societies are examined, and our own child training is placed in this broad human perspective. It is therefore a contribution to the mass of evidence on the effects of child training on personality, correlating them with the origins of guilt, projection, displacement and fixations.

Atmospheric Pollution—Its Origin and Prevention, by A. R. Meetham, D.S.C. (*Pergamon Press Ltd., London, England*). According to this authority over eight million tons of atmospheric pollution are produced each year in Great Britain from the combustion of coal and its derived fuels. This is the cause of more damage than pollution from any other source. It is, therefore, the main subject of this book which treats of the problem in a most thorough manner. It is a book of reference for anyone interested in smog.

The Bile Pigments, by C. H. Gray, M.D. ($1.75. *Methuen & Company, London, England.* U.S. Distributor: *Wiley (John) & Sons, Inc., New York 16, N.Y.*). This book covers those substances whose molecules consist of a chain of four pyrrole rings as well as some derivatives such as dipyrryl compounds. The work itself is a readable and useful account of bile pigments with special reference to man.

Heart and Circulation: Diagnosis and Treatment, by Meyer Sclar, M.D. ($7.50. *Froben Press, Inc., New York 19, N.Y.*). This book has been written for the general practitioner and gives a very workable approach to the patient with heart disease.

The Oxford Medicine Volume VIII—The Medical Treatment of Diseases, ($25.00. *Oxford University Press, New York 11, N. Y.).* A revision of this volume of this well-known, outstanding system of medicine.

Trichlotyhlene Anesthesia, by Gordon Ostlere, ($2.25. *E. & S. Livingston, Ltd., Edinburgh and London;* U. S. A. distributors: *Williams & Wilkins Co., Baltimore 2, Md.),* represents an attempt to analyze the published work on trichlotyhlene by a competent authority.

Your Body and Mind, by Frank G. Slaughter, M. D., ($0.25. A Signet Book. *The New American Library, New York 22, N. Y.).* A typically mod-

ern explanation of the influence of "mind" (sic) over body, done in a popular reprint by the well-known fiction writer and surgeon.

Clinical Orthopaedics, Volume I, by Anthony F. DePalma with five associate editors and six advisory editors, ($6.00. *J. B. Lippincott Co., Philadelphia 5, Pa.)*, represents a new type of publication sponsored by The Association of Bone and Joint Surgeons and designed for the prompt publication of original articles offering significant contributions to the advancement of surgical knowledge. In this volume, some twenty-five important topics are presented—fifteen dealing with disorders in children and ten with general orthopaedics.

Adjustments to Physical Handicaps and Illness: A Survey of The Social Psychology of Physique and Disability, by Roger G. Barker, with Beatrice A. Wright, Lee Meyerson, and Mollie R. Gonick, ($2.00. Bulletin 25. *Social Science Research Council, 230 Park Ave., New York 17, N. Y.)*. A skillful attempt is made to develop a theoretical framework of the inter-relations between the constitutional disabilities and illnesses and the person's reaction to them. Some guidance can be obtained from the work although the investigation itself is not conclusivve.

Tumors of The Orbit and Allied Pseudo Tumors, by Raymond G. Ingalls, M. D., ($11.50. *Charles C. Thomas Co., Springfield, Ill.)*, illustrates by means of photographs of patients, the important features of these neoplasms. It is, in fact, an analysis of 216 orbital tumors with their histories, microscopical description, and a report on the end result.

Health Facts for College Students, by Maude Lee Etheredge, M. D., ($4.00. Sixth Edition. *W. B. Saunders Co., Philadelphia 5, Pa.)*. While the author recognizes that at the present time there is too much introspection about the control of the "mind" and its relation to the body, nevertheless the most important part of college training is to learn how to use one's brain and nervous system. Good hygiene will always be the basis for emotional stability.

Pathology, Edited by W. A. D. Anderson, M. D., ($16.00. Second Edition. *The C. V. Mosby Co., St. Louis 3, Mo.)*. Under an efficient editor, a long list of distinguished pathologists have produced and revised a one-volume text which is both comprehensive and balanced.

The Art of Good Speech, by James H. McBurney and Ernest J. Wrage, of the Speech Department of Northwestern University, ($6.00. *Prentice-Hall, Inc., New York 11, N. Y.)*. Most of us physicians speak rather badly. "No one can master an art simply by learning the principles upon which it is based; people who understand the principles have a much better chance of exercising the art in a masterful way." Hence, most of us should study this text if we wish to be more effectual.

Physiology of The Eye: Clinical Application, by Francis Heed Adler, M. D., ($13.00. Second Edition. *The C. V. Mosby Co., St. Louis 3, Mo.)*, provides a book which offers to the student and practicing ophthalmologist the recent findings of the physiology of the eye gleaned from the experimental laboratory, and to relate these facts wherever possible with clinical concepts.

A Modern Practice of Obstetrics, by D. M. Stern, M. D., and C. W. F. Burnett, M. D., ($7.00. *Bailleke, Tindall and Cox, 8 Henrietta St., W-C 2, London, England.* U. S. A. Distributor: *Williams & Wilkins Co., Baltimore 2, Md.)*. Sets out the practice of obstetrics at the West Middlesex Hospital and is the result of experience gained from some 50,000 consecutive deliveries during the past 16 years.

Holt Pediatrics, by L. Emmett Holt, Jr., and Rustin McIntosh, ($15.00. 12th Edition. *Appleton-Century-Crofts, New York 1, N. Y.)*. Since 1896 a standard text amply revised by a large staff of contributors thereby bringing together all of the amazing advances of the last decade.

Diseases of Women, by Robert J. Crossen, M. D., ($18.50. Tenth Edition. *The C. V. Mosby Co., St. Louis 3, Mo.)*. Published in 1907 by Harry S. Crossen, M. D., now entirely in the hands of its present author, the book brings together the basic facts and salient developments of the biologic and physiologic investigations which are now making history in this field, in a comprehensive, systematic, yet judicial manner.

Psychoanalysis and Social Work, Edited by Marcel Heiman, M. D., ($5.00. *International University Press, New York 11, N. Y.)*. For good or ill, psychoanalysis as a system of psychology and as a therapeutic discipline has been felt by every field of the social "sciences." Social work has itself felt the heavy hand of this new tool. This text is an attempt to make complementary to each the accomplishment and theories of the other.

The Living Brain, by Grey Walter, ($3.95. *W. W. Norton & Co., Inc., New York 3, N. Y.)*. Here a world-famous authority describes the modern mass of knowledge which electroencephalography has given us—new objectively demonstrated facts about memory, lunacy, crime, hypnotism, sleep and fatigue. A refreshing book to those of us who are skeptical of all the fantasies contributing to the influence of "mind" over body.

The Untouchables, by Alfred Maund. Illustrated by Ben Shahn, ($0.50. *The Southern Conference Educational Fund, Inc., New Orleans 12, La.)*, is a fighting pamphlet on social discrimination.

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Vol. 50 July, 1954 No. 7

JONATHAN FORMAN, M. D., *Editor*

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Acute Meningovascular Syphilis During the Poliomyelitis Season*

SAMUEL SASLAW, M. D., Ph. D., and MARVIN SAKOL, M. D.

DURING an epidemic, poliomyelitis is entertained as a possibility in any central nervous system disease of acute or subacute onset, particularly when associated with fever, meningeal signs or symptoms, and asymmetrical muscular paresis. This possibility is enhanced when a lymphocytic pleocytosis is found upon spinal fluid examination. Some of the more common entities where poliomyelitis is not infrequently considered in the differential diagnosis are tuberculous meningitis, the virus encephalitides and less frequently leptospiral, yeast and fungus infections. Gordon[1] noted that only half of 446 patients admitted as having poliomyelitis were confirmed as such. Silverstein and Lucchesi[2] found 98 of 315 suspected cases did not have poliomyelitis. Of these, three proved to have acute syphilitic meningitis.

The purpose of this report is to describe two cases of acute meningovascular syphilis occuring during an epidemic of poliomyelitis and admitted to the hospital as poliomyelitis suspects.

The Authors

● Dr. Saslaw, Columbus, is associate professor of Medicine and Bacteriology; assistant professor, Department of Preventive Medicine, Ohio State University, and director of Infectious Disease Service, University Hospital.

● Dr. Sakol, Louisville, Ky., formerly assistant resident at University Hospital, Columbus, is now resident in medicine at Louisville General Hospital.

CASE REPORTS

Case 1. A 30 year old white male was admitted to University Hospital on September 4, 1951. The history was obtained from his mother. He was apparently well until four weeks prior to admission at which time he suddenly became unable to speak, and noted weakness in his right upper and lower extremities with dragging of the right foot. About two days later his speech began to return as did the use of his right arm and leg. He had had no trouble walking, eating or talking since that time until two days prior to admission when he again noted the loss of his voice and weakness of the right upper and lower extremities, incontinence of urine and feces, and difficulty in swallowing.

In the four week interim between attacks he had complained of two headaches mostly centered in the vertex. There was no history of nausea, vomiting, convulsions or mental confusion. Eleven years prior to admission he had what was probably an anal fistula, and eight years previously had gonorrhea. About five to six years before admission he had a sore on his penis which disappeared in about three to four weeks without therapy.

Physical examination revealed a well developed, well nourished, white male with normal vital signs. He seemed alert, oriented and was cooperative. He was aphonic attempting to frame words with facial muscles, but unable to produce sounds except a weak "Oh." There was a lag of the soft palate. Uvula deviated slightly to the right. The optic discs revealed venous congestion with elevation of the vessels and early papilledema. The right pupil was larger than the left. Both pupils reacted to light and accomodation but the left reacted sluggishly.

The oral pharynx was slightly injected. He

*From the Department of Medicine, College of Medicine, Ohio State University.
Submitted January 26, 1954.

had difficulty swallowing. The neck was supple. Examination of the lungs revealed bilateral inspiratory crepitant rales in the bases. Heart showed a regular rhythm with no thrills or murmurs. There was a moderate degree of right hemiparesis with hyperreflexia. He was unable to protrude the tongue or produce lateral motion. Weber and Rinne's tests were normal. Corneal reflexes were 2 plus bilaterally. No abdominal reflexes were present. There was a sustained ankle clonus on the right and an unsustained clonus on the left. Babinski's reflex was positive bilaterally. On the glans penis was a small area of old scarring.

Laboratory Data. An initial lumbar puncture showed an opening pressure of 180 mm. of water, a closing pressure of 90 mm.; 18 cc. of crystal clear fluid was removed. Dynamics were normal. This spinal fluid showed 178 red cells per cu. mm., 137 white cells per cu. mm., 64 per cent neutrophils, 36 per cent lymphocytes; globulin (Ross-Jones) was positive; protein 150 mg. per 100 ml.; sugar 31 mg.; chlorides 698 mg. Colloidal gold was 4444432210. Wassermann and Kahn tests were positive. Admission blood count showed 19,100 white cells with 79 per cent neutrophils. Urinalysis was normal.

After nine days of penicillin therapy a repeat lumbar puncture was done which showed essentially normal manometrics, 3 red cells per cu. mm., 80 white cells per cu. mm., 80 per cent lymphocytes; positive Pandy test; 78 mg. per 100 ml. protein; 60 mg. sugar; 792 mg. chlorides. Colloidal gold 5554321100. Positive serology with 120 Kahn units.

Repeat lumbar puncture seven weeks later, and after 25 million units of penicillin, showed normal fluid dynamics; no cells; negative globulin; 54 mg. per 100 ml. protein; a colloidal gold of 1111000000; positive Kahn (40 units). Blood serology was 8 Kahn units. Complement fixation tests for mumps, lymphocytic choriomeningitis, Eastern and Western equine encephalomyelitis and St. Louis encephalitis were negative.

The patient continued to have sustained ankle clonus on the right. At the time of discharge he was able to speak with much difficulty, being unable to pronounce polysyllabic words, but he could eat well and control his bowel and urinary bladder.

Follow-Up: One year and five months after discharge he still had difficulty in swallowing liquid although his muscle coordination had improved considerably, especially in the arm. The right arm and leg were slightly weaker than the left. He was still unable to coordinate his larynx and pharynx and had a considerable amount of dysarthria. His blood serology (VDRL) was positive at 1:8 dilutions.

Case 2. This 32 year old white male was admitted to University Hospital on September 19, 1951, after three admissions to other hospitals. The history as obtained after the admission and just prior to death was that he was a chronic alcoholic who three weeks before had been on his usual "Saturday night drunk." The next morning he stated that while walking home he had fallen on a railroad track and rolled down a small embankment causing a laceration over the right supraorbital process and above the right ear. From this day on until one week prior to admission he complained of a right side headache.

There had been no nausea, vomiting, diplopia or blurring of vision. About two weeks before, he awoke in the morning with a right hemiplegia and paralysis of the lower half of the right side of the face and slurred speech. He had gone to bed with no evidence of weakness or paralysis. He was admitted to another hospital with the admitting impression of "stroke." During his hospital stay there, there was almost complete resolution of the paralysis, facial asymmetry and slurred speech. He was discharged from that hospital eight days prior to admission here.

Three days prior to admission to University Hospital he again had a hemiparesis, this time with involvement of the left side and absence of ability to speak. However, he was rational and able to respond to commands by nodding of the head. When seen at another hospital his neck was supple; Brudzinski and Kernig's signs were negative. He had a left spastic hemiplegia. There were bilaterally positive Babinski's. Oppenheim, Chaddock's and Gordon's tests were positive bilaterally. There were hyperactive knee jerks bilaterally. There was right ankle clonus and a dilated right pupil. The extraocular muscles were full and free. There was inability to protrude the tongue. There was a very weak swallowing reflex. The patient was alert and responded to all verbal commands. Roentgenograms of the skull revealed no fracture. There were no pineal calcifications seen. Blood count at that time revealed 16,400 white cells, with 77 per cent neutrophils. A lumbar puncture revealed an initial pressure of 180; 96 white cells, with 53 per cent lymphocytes, 47 per cent neutrophils and 21 red cells.

The patient was then transferred to another hospital with a diagnosis of "bulbar poliomyelitis." In that hospital it was noted that the left pupil was dilated, but both pupils reacted sluggishly to light. Laboratory examination there revealed a positive blood test for syphilis whereupon the spinal fluid was tested also and found to be positive. Lumbar puncture there showed 42 white cells with 39 per cent neutrophils; normal sugar and a protein of 65 mg. per 100 ml. Colloidal gold was 5443221000. Heterophile agglutinations were negative. A diagnosis of central nervous system lues was made, and the patient transferred to University Hospital.

Physical examination on admission at University Hospital revealed a patient apparently in extremis. His temperature was 101.8; pulse 100; respirations 30. The skin was warm and moist. His head was thrown back. He was breathing with his mouth and gazing at the ceiling. He was completly aphonic. However, he did move his eyes as directed. Eyes and ears were normal except for a perforated right drum. Mucous membranes were dry; tongue was coated. He had several markedly decayed teeth; oral hygiene was poor. There was no gag reflex; no nuchal rigidity.

Chest was symmetrical with prominent sternum. There were rhonchi and rales throughout both lungs. There was increased superior mediastinal dullness. The point of maximal impulse was at the 5th intercostal space at the midclavicular line. There was a systolic aortic murmur. The abdomen, lymph nodes and extremities were all within normal limits. Neurological examination revealed hyperactive knee jerks and ankle jerks, normal upper deep tendon reflexes. There were absent superficial reflexes. There was positive bilateral Babinski's, negative Hoffman's.

A lumbar puncture at that time revealed 1 red cell per cu. mm., 149 white cells per cu. mm., 2 per cent neutrophils, 98 per cent lymphocytes; protein 38 mg. per 100 ml.; sugar 57.5 mg.; chlorides 800 mg.; colloidal gold was 4443321000.

Spinal fluid Wassermann and Kahn tests were positive.

The patient was placed immediately on penicillin therapy, but expired approximately 36 hours after admission.

Autopsy (Drs. T. K. Batson and G. R. Straub) revealed the dura to be gray and shiny, the leptomeninges thin and transparent except for opaque areas scattered over the superior portions of the cerebral hemispheres. The subarachnoid fluid was clear. The brain weighed 1400 grams. The convolutional patterns were normal. The basilar artery was markedly thickened for a distance of 1 cm. At a point 1 cm. posterior to the middle cerebral artery the thickening extended for a distance of about 1.5 cm. However, the lumen was patent. The veins were prominent, slightly dilated and dark red over the cerebral hemispheres. The pituitary gland was normal in size and shape. The dural sinuses were patent. The middle ear was dry. The fixed brain on section showed scattered small petechiae in the basal nuclei, substancia nigra and pons. There was an area of hemorrhagic softening located in the left pons. There was perivascular cuffing consistent with a luetic meningo-encephalitis.

Autopsy also revealed a left lower lobe lobular pneumonia, luetic aortic valvulitis, early Laënnec's cirrhosis of the liver and cholelithiasis.

DISCUSSION

In reviewing these two cases, it is apparent that each presented some signs or symptoms suggesting poliomyelitis. This latter possibility was made even stronger since both patients were seen during the late summer season.

The typical case of poliomyelitis with fever, gastrointestinal or upper respiratory symptoms followed by headache, nuchal rigidity and muscle pain can be recognized more readily. Subsequent paralysis within a few days practically insures the diagnosis. However, certain persons with poliomyelitis may have no fever or prodromata with paralysis appearing as the first sign of disease. Both patients reported here had asymmetric paralysis and spinal fluid findings which could be compatible with paralytic poliomyelitis on first inspection.

Luetic meningitis can be divided into 3 major groups:

(1) Those with basilar meningeal signs, predominantly cranial nerve palsies.

(2) Predominantly cerebral vertex signs such as hemiplegia, aphasia, convulsions or delirium.

(3) Acute hydrocephalic with headache, nausea, vomiting, meningeal signs and choked discs.

Both patients reported here fell into group two. The speech disturbances observed were not characteristic of poliomyelitis and resulted in further investigation which was rewarded by positive spinal fluid serologies. Since acute meningovascular syphilis is not too frequently encountered or reported, general experiences with this manifestation of the disease are limited. However, consideration of luetic meningitis should not be neglected when meningeal or encephalitic syndromes, or nervous disorders with paralytic phenomena are encountered. The value of spinal fluid serologies in differential diagnosis may be considerable in such instances.

SUMMARY

1. The problems in the differential diagnosis of central nervous system disease during an epidemic of poliomyelitis is noted.

2. Two cases of acute meningovascular syphilis occurring during a polio epidemic are reviewed.

3. The importance of a spinal fluid serology in atypical cases of suspected poliomyelitis is stressed.

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2. Silverstein, A., and Lucchesi, P. F.: ibid.

KEEPING UP WITH MEDICINE

• WAR—THE OUTSTANDING symptom of Man's disordered behavior, has today reached the acme of its expression. It has become a phyletic phenomenon.

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• IN 1886 ERLICH first reported the use of dyes for the study of the central nervous system. Today the selective passage of substances from the blood into the central nervous system is being used for localization of brain tumors.

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• IN SCLERODERMA partial remisisons have followed the use of ACTH or cortisone but the results have not been too encouraging in the majority of cases reported to date.

* * *

• THE SIMULTANEOUS USE of atropine or hyoscine preparations with the antihistaminics is contraindicated because the antihistamines do have a hyoscine-like action.

* * *

• THE USE OF antihistamines in asthma has proved extremely disappointing and most authorities are now agreed that they are of little value in this condition.

* * *

• WHEN PATIENTS receiving antibiotic therapy exhibit changes in the oral buccal membranes, changes are in all likelihood occurring throughout the gastrointestinal tract. Most often Candida (Monilia) are overrunning the alimentary flora and even becoming pathogenic.

* * *

• THE BLACK TONGUE which often occurs during penicillin therapy is thought to be due to a fungus.

* * *

• THE DIARRHEA following antibiotic therapy is more probably the result of a deficiency state from the destruction of the normal flora rather than an infection with Candida albicans.—J. F.

Dysrhythmic Migraine

ANDRÉ A. WEIL, M. D.

A REVIEW of the literature discloses that 26.5 to 58 per cent of migraine patients have abnormal electroencephalograms.[1] On the other hand, Gibbs[2] states that migraine patients show only slightly more EEG abnormalities than normal subjects. Strauss[3] postulates even that "abnormal records obtained in the headache free interval should certainly suggest the presence of an additional disorder." However, the diagnostic criterion for "migraine" is not always clearly defined by the authors; many reports fail to indicate whether the recordings were done during the free interval or during an attack.

Reporting on migraine patients in 1951, this author[4] found abnormal to maximal abnormal EEG's in 26 per cent of typical migraine cases; this group also showed characteristic neuropsychiatric and therapeutic correlates deeming it permissible to consider it as a migraine subtype: *Dysrhythmic Migraine.* This report deals with additional EEG-clinical observations and follow-up.

CLINICAL MATERIAL

Included are 42 migraine cases, ten (24 per cent) fulfilling the EEG-clinical requirements for "dysrhythmic" migraine classification. (Figure 1.) Nine of the ten dysrhythmic migraine patients were females. The ages of the patients varied between 14½ and 54 years. Contrary to "ordinary" migraine, attacks started in childhood or much later in life; there was a positive family history for migraine in only two subjects. Family history of convulsions was non-contributory in all ten subjects; past history indicated febrile convulsions in infancy in only one subject.

OBSERVATIONS

EEG Observations:

(a) During free interval:

"Ordinary" migraine shows usually normal or borderline EEG. There is no definite hyperventilation activation.

"Dysrhythmic" migraine records reveal: (Figure 2.)

1) Paroxysmal 2½-5½/sec. bursts (75-200μV) occasionally with focal accentuation (5 patients).
2) High voltage (100-150μV), 6-7/sec. activity, usually with random spikes (3 patients).
3) Mixture of No. 1 and No. 2 (2 patients). (Figure 3.)
4) Marked hyperventilation activation in all subjects, usually paroxysmal.

(b) During attack:

"Ordinary" migraine reveals occasionally slight dissociation of pattern with isolated sharp waves.

"Dysrhythmic" migraine shows EEG similar to Hyperventilation-EEG during free interval. (Figure 4.)

Neuropsychiatric Observations:

Attacks seem less frequent, but of much longer duration than observed in "ordinary" migraine. Besides the common neurological findings of migraine (unilateral cephalgia, scotomata, nausea and vomiting, paresthesiae and polyuria), we noted occasional attacks of **syncope** at the height of an ictus in 7 patients, **aphasic** episodes in 5 patients. All subjects displayed profound psychoneurotic traits. Contrary to "ordinary" migraine, attacks were almost universally precipitated by acute stress.

Pharmacologic-Therapeutic Observations:

The medications of choice for migraine (caffeine, ergotamine tartrate, dihydroergotamine, etc.)[5] were usually alone not effective. All patients benefited by an addition of anticonvulsants (5.5 diphenylhydantoin [dilantin®] or 3-methyl-5,5-phenyl-ethylhydantoin [mesantoin®]) to the previously mentioned drugs. For maintenance treatment, a combination of ergotamine tartrate, bellafoline® and phenobarbital (bellergal®) seems particularly effective when combined with small doses of dilantin®. Psychotherapy appears essential in spite of the "organic" type of EEG. All patients could be relieved of an acute migrainous ictus by sodium isoamyl-ethyl--barbiturate (sodium amytal®) or sodium phenobarbital intravenously, particularly when combined with Dihydroergotamine (DHE 45®) intramuscularly. DHE 45® alone was never effective, contrary to "ordinary" migraine.

FOLLOW-UP

Two patients could not be followed.

Four subjects are at present free of attacks, three of them for over two years. The "neurotic"

The Author

● **Dr. Weil, Cleveland, president (1953-54) of the Cleveland Society of Neurology and Psychiatry, is assistant visiting neurologist at City Hospital, Cleveland.**

Read at the Third International Congress of Electroencephalography and Clinical Neurophysiology, Cambridge, Mass., August 18, 1953.

From the Department of Neurology, Western Reserve University (City Hospital, Cleveland) and author's private laboratory.

"ORDINARY" MIGRAINE VS. "DYSRHYTHMIC" MIGRAINE

	"ORDINARY" MIGRAINE	"DYSRHYTHMIC" MIGRAINE
EEG	Free Interval: Usual normal or borderline record. No definite hyperventilation activation.	1) Paroxysmal slow wave bursts, 2½-5½/sec - 75-200μV, occasionally with focal accentuation OR 2) High voltage (100-150μV) spiky 6-7/sec activity 3) Always marked hyperventilation activation.
	During Attack: Slight dissociation of pattern with isolated sharp waves. Frequently no abnormal findings.	Similar to hyperventilation record.
FAMILY HISTORY	Usually indicative of migraine.	Usually non-contributory.
NEUROLOGICAL SIGNS AND SYMPTOMS	1) Unilateral cephalgia 2) Scotomata 3) Nausea and vomiting 4) Diarrhea and polyuria	Same as ordinary migraine plus Syncope (70%) Aphasic episodes (50%)
PSYCHIATRIC SYMPTOMS	Variety of psychoneurotic (occasionally psychopathic) traits are frequent	Always psychoneurotic elements a) Anxiety reactions b) Repressed guilt and hostility
	Attacks occasionally precipitated by acute stress.	Attacks most frequently precipitated by acute stress.
TREATMENT	In Free Interval: Psychotherapy Caffeine Ergotamine tartrate, etc. Occasional endocrine therapy.	Psychotherapy essential 5.5 Diphenylhydantoin (Dilantin) 3-methyl-5,5-phenyl-ethylhydantoin (Mesantoin) Phenobarbital in small doses plus Ergotamine tartrate, Bellafoline and Phenobarbital (Bellergal)
	During Attacks: Dihydroergotamine (D.H.E. 45) i.m.	Sod.Isoamyl-ethyl-barbiturate (Sod.Amytal) i.v. plus D.H.E. 45 i.m.

Fig. 1. "Ordinary" migraine compared to "Dysrhythmic" migraine.

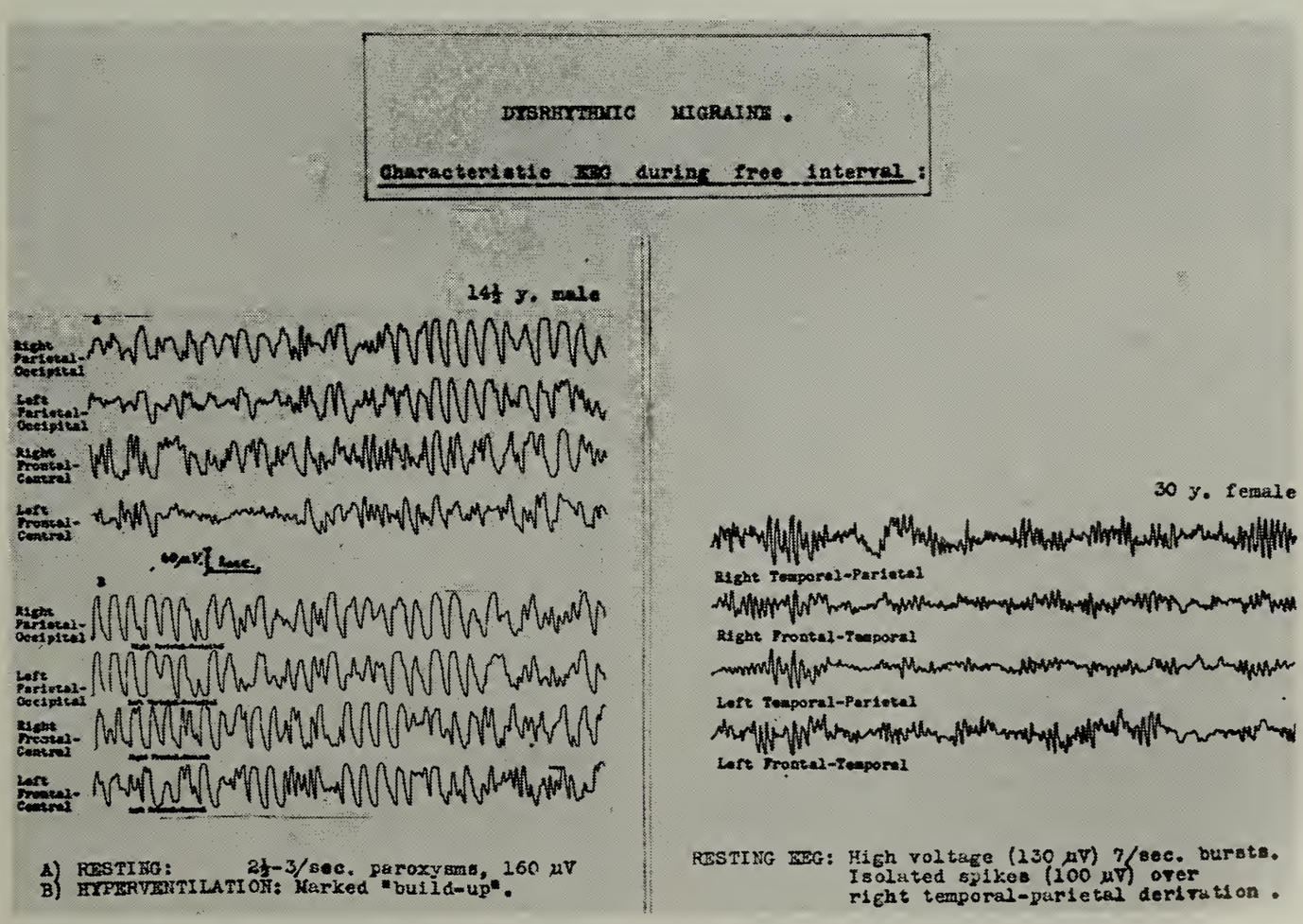


Fig. 2. EEG during free interval showing two characteristic irregularities in dysrhythmic migraine.

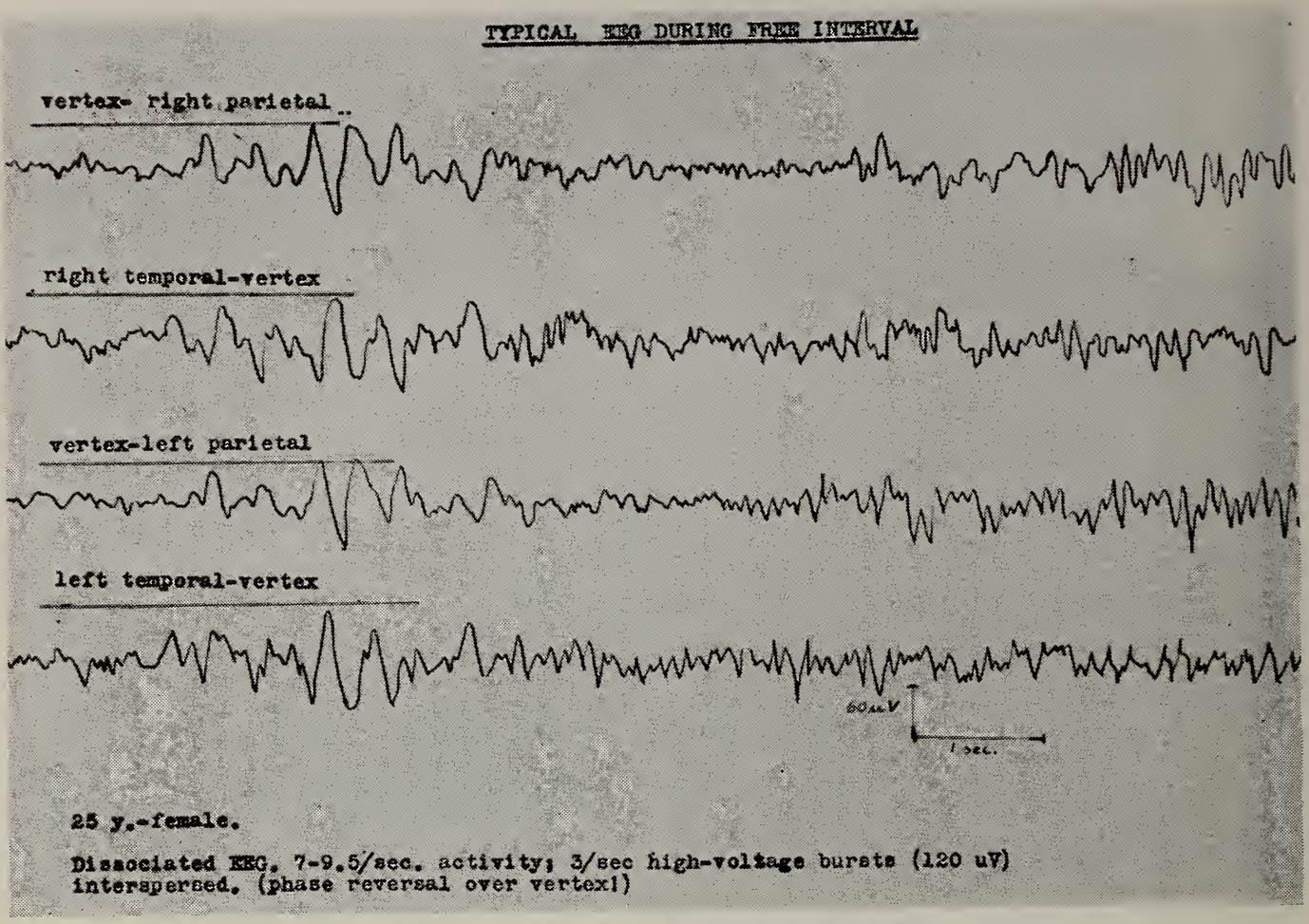


Fig. 3. Typical paroxysmal slow activity in attack-free time.

traits of these patients have correspondingly shown marked improvement.

Four subjects may be classified as displaying grades of improvement. Two patients of this group had relapses after medication was discontinued, but are again free of migraine attacks under medication.

Clinical improvement is usually followed by "improvement" of the EEG. (Figure 4.)

DISCUSSION

Figure 1 tabulates the main differential points between "ordinary" migraine and "dysrhythmic" migraine. The differential diagnosis rests mainly on the EEG. However, certain clinical observations as well as the therapeutic effect of anticonvulsant medication add further strength to the concept that dysrhythmic migraine is a particular subtype of migraine.

Migraine headaches are usually considered due to constriction followed by dilatation of certain extracranial and dural arteries. Relaxation of the vessel walls follows and causes an overstimulation of the extracranial and dural arterial plexuses.[6] Ergotamine tartrate seems to have a specific action constricting dural and temporal branches of the external carotid artery without affecting branches of the internal carotid.[6] Gibbs, Gibbs and Lennox[7] as well as Dow[8] demonstrated clinical and EEG changes after ergotamine tartrate administration in migraine cases which were not observed in our series. Therefore, some other mechanism seems to cause vasodilation in our series not responsive to ergotamine tartrate.

The EEG of dysrhythmic migraine patients shows regularly gross activation during hyperventilation, indicating (1) incompetence of homeostatic mechanisms and (2) sensitivity of the cerebral neurons to low carbon dioxide tension.[9] All our subjects showed severe autonomic imbalance. Hyperventilation EEG build-up is usually missing in "ordinary" migraine. The occurrence of dysrhythmic migraine bouts after emotional "shock" (hyperventilation!) appears characteristic.

This does not explain the occurrence of slow-wave bursts in the resting EEG and the response to anticonvulsant medication. R. Cohn[1a] observed, too, that "a large number of individuals with slow activity associated with the migraine syndrome respond very satisfactorily to anticonvulsant medication." The electroencephalograms of our series resemble the ones observed in "cryptogenic" convulsive disorders. It has been known that migrainous attacks may alternate with epileptic convulsive seizures.[10] This was not the case in our dysrhythmic migraine patients, nor did the family history indicate epilepsy. The attacks of syncope were infrequent, brief, associated with pallor, low blood pressure and without convulsive movements.

It appears, therefore, that dysrhythmic migraine is predominantly a disorder of autonomic balance. There exists clinically, and in the EEG, evidence for (1) **incompetence of homeostatic mechanisms** and (2) oversensitivity of cerebral

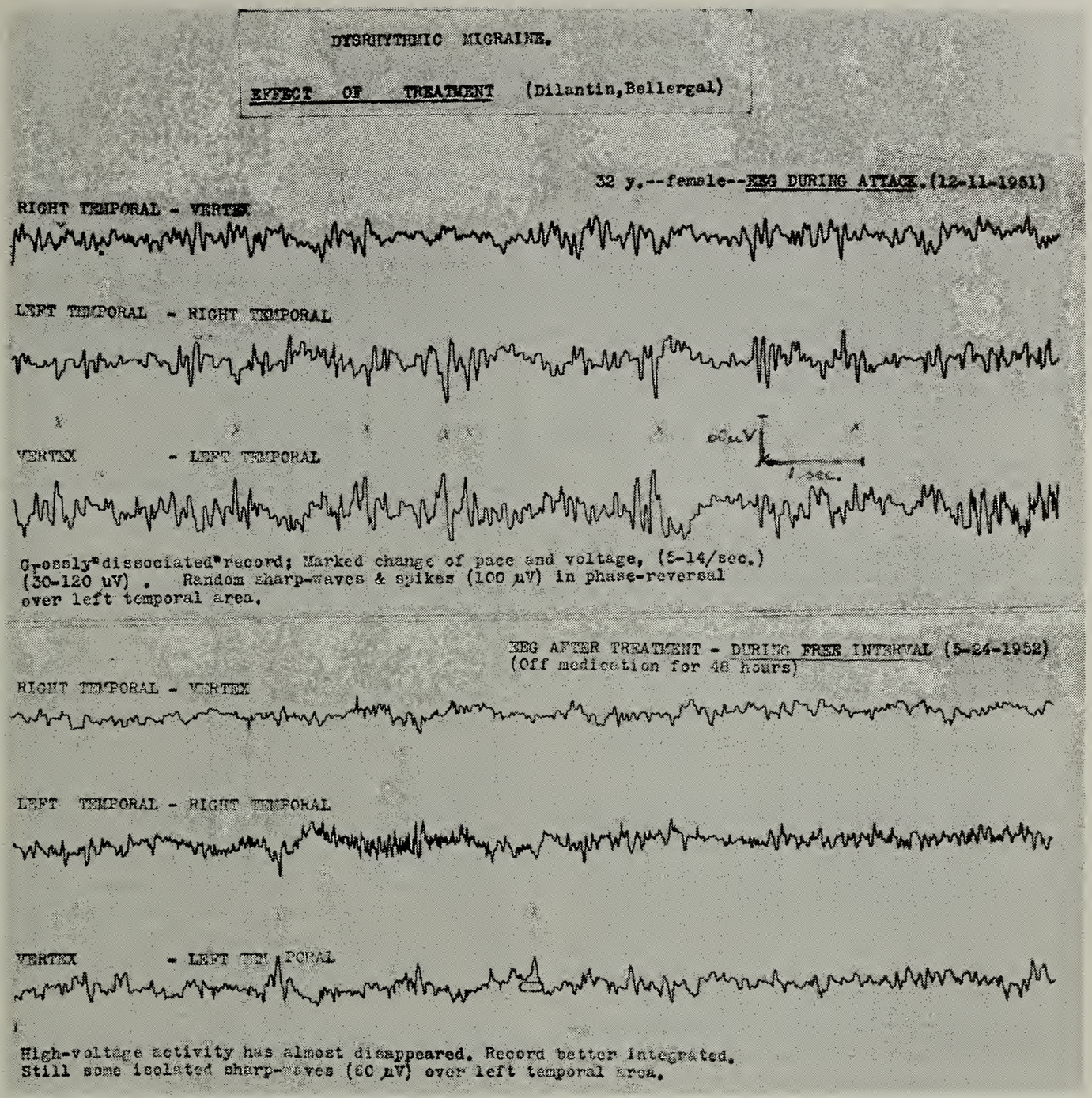


Fig. 4. EEG during dysrhythmic migraine attack and during free interval (effect of treatment).

mechanisms to acapnia. Whether (3), an epileptic "diathesis" (delta-paroxysms, effect of anticonvulsant) can be postulated appears doubtful.

SUMMARY

Forty-two migraine patients were studied clinically, pharmacologically and by EEG. Ten subjects (24 per cent) showed abnormal to grossly abnormal electroencephalograms as well as neurological-psychiatric findings and pharmacological responses usually not observed in "ordinary" migraine. This, together with follow-up studies, seems to justify the term "dysrhythmic migraine" for these patients.

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Recent Developments in the Field of Poliomyelitis

A Review

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THE YEAR 1953 has been a most significant one for the National Foundation for Infantile Paralysis and the many investigators whom it financially supports. The efforts of investigators over many years are just now about to produce significant results. The thought that a disease that is so feared by lay people as well as physicians may soon be controlled is indeed exciting.

CLINICAL REVIEW

An analysis of 263 patients observed during the 1950 poliomyelitis epidemic at Kingston Avenue Hospital is presented.[1] The cases were classified as follows:

	Number of Cases	Per Cent	
Non-paralytic	71	26.9	
Encephalitic	22	8.3	22.7
Bulbar	38	14.4	
Spinal	132	50.4	

Signs and Symptoms: Fever and lethargy were present in almost all cases. Constipation was present in most of the patients and was extremely troublesome in some. In order of frequency the following complaints were noted: headache, muscle pain, nausea or vomiting, stiff neck, stiff back, dromedary fever, arterial tenderness, generalized weakness, dysphagia, nasal voice. Uncommon or occasional complaints included hoarseness, aphonia, diplopia, syncope, strabismus, delirium, tremors, nystagmus, dyspnea, and diarrhea.

No correlation was found between the length or severity of the prodromal stage and the final form taken by the disease. Twenty-one, or 16 per cent, of patients with paralytic poliomyelitis had no fever, either at time of onset or during the entire hospital stay. There was no direct correlation between fever at time of onset and type or severity of the disease. In the average case the fever lasted for 5 to 7 days.

Spinal fluid cell count ranged from 0 to 1000 cells. Over 60 per cent of cases had a count between 10 and 200, the greatest number in the 50 to 100 cell count range. Early in the disease occasionally polymorphonuclears predominated. Five per cent of the patients had no pleocytosis on admission. Spinal fluid protein values ranged between 40 and 100 mg. per 100 ml. There was no correlation between the severity of the disease or of its form with either the amount of spinal fluid protein or with the cell count in the spinal fluid.

Leukocyte counts ranged between 5,000 and 16,000 cells per cubic millimeter. Differentials were normal. Where extreme leukocytosis or granulocytosis occurred, a complication was suspected or the presence of a disease other than poliomyelitis.

SIGNIFICANCE OF HYPERTENSION STUDIED

Hypertension as a symptom of acute poliomyelitis has only recently been described. The significance of severe hypertension as a potential cause of death in acute poliomyelitis is under study at the present time. An excellent report on the incidence of hypertension and its possible causes is that of M. A. Perlstein, et al.[2]

This report covers an observation of 195 cases of poliomyelitis at the Municipal Contagious Disease Hospital of Chicago and the Michael Reese Hospital of Chicago from July 1950 through December 1950. Two-thirds of the 195 patients were paralytic (133); one third non-paralytic (62); two-thirds (130) had no elevation and one-third (65) had definite evidence of elevated blood pressure at some time during the course of the illness. The incidence of hypertension was over three times as great in the presence of paralysis (43 per cent of 133 cases) than in its absence (13 per cent of 62 cases).

The incidence of hypertension was not related to the presence of respiratory difficulties since in both the groups with and without respiratory difficulties the incidence of hypertension was 45 per cent. This would indicate that anoxia or respiratory embarrassment per se probably is not a primary factor in the causation of hypertension.

On the assumption that neurologic involvement in areas controlling vasomotor functions might

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Submitted April 12, 1954.

be responsible for the hypertension, one might expect to find a greater incidence of hypertension in patients with high cervical involvement than in those with low cervical involvement. However, the incidence of hypertension with upper extremity involvement differed little from that with lower extremity involvement. The highest incidence of hypertension occurred in the 22 patients with intercostal involvement (55 per cent). The number of cases is too small from which to draw definite conclusions. The incidence of hypertension was not significantly greater in those with bulbar or encephalitic involvement than in those from the general group of paralysis.

The authors were unable to find any consistent findings which would indicate kidney damage. The hypertension was of transient type lasting two to four days. The minimal rise in diastolic pressure was 15 mm. Hg; the highest rise 63 mm. Hg.

Four possible factors which might predispose to this transient hypertension in acute poliomyelitis were listed: (1) disturbed renal function; (2) anoxemia; (3) psychogenic factors; (4) involvement of the vasopressor center in the brain stem. Of these four, the authors believe involvement of the brain stem the most likely cause. The association of damage to the large reticular cells located in the ventromedial reticular area with clinical symptoms or vasomotor disturbances has been demonstrated frequently. The damage to these cells could readily explain the transient hypertension encountered occasionally in the case of non-paralytic poliomyelitis.

INCIDENCE OF POLIOMYELITIS AMONG PREGNANT WOMEN

The problem of the relationship of pregnancy to the incidence and severity of poliomyelitis is discussed by Stephen W. Cobb, et al.[3] The summary of his findings are as follows:

Congenital malformation does not seem to occur with poliomyelitis as with rubella.

Generally, the mortality rate of poliomyelitis occurring during the third trimester of pregnancy is greater than that for the first two trimesters. Horn, with 179 patients from Los Angeles County Hospital, presents a notable exception to this group of reports. A significant feature of her paper was: that the incidence and mortality rates of bulbar spinal forms were similar for each trimester of pregnancy. In other words, seriously ill patients die because of the disease and not because of the associated pregnancy.

During normal pregnancy there is a progressive increase in vital capacity, respiratory rate, volume of tidal air, and minute volume of respired air. The diminished height of the pleural cavities is compensated by increased width. Normally, there is no embarrassment of respiration caused by, or related to, pregnancy. Respiratory embarrassment in the pregnant woman with poliomyelitis is usually due to the disease and not to the pregnancy. There are no acceptable data or other evidence to suggest that proper ventilation in respirator patients is interfered with by a pregnant uterus near term.

We believe the pregnancy should be ignored unless the patient is about to die or is in labor. Fetal salvage efforts in moribund patients are often unsuccessful.

Obviously the laboring patient must be delivered as expeditiously as possible, reserving cesarean section for obstetric indications. We believe the operation is rarely, if ever, indicated by the disease alone.

CONTINUED STUDY OF THE RELATIONSHIP OF TONSILLECTOMY TO POLIOMYELITIS

Many studies have been done over the past 10 years in an attempt to understand the relationship of tonsillectomy to poliomyelitis. The overwhelming evidence is that a definite relationship exists. Another excellent study appeared this past year from Evanston, Illinois.[4] The conclusions from this study are that tonsillectomy does significantly increase the incidence of bulbar poliomyelitis when done during epidemics.

The over-all incidence is probably increased but perhaps only by the increase of bulbar poliomyelitis. Elective tonsillectomies should be restricted in epidemic periods. Investigation should be made of a similar relationship of dental and other oral and general operations to poliomyelitis and the need of restricting them in epidemic periods.

RELATIONSHIP OF PREVIOUS INJECTIONS OF PENICILLIN AND VARIOUS SUBSTANCES

Spencer F. Brown[5] points out that since 1950 in an attempt to determine whether any relationship exists between penicillin injections and the development of paralysis during acute poliomyelitis, he studied 385 polio patients admitted to the Elizabeth Kenny Institute and found no relationship between paralysis occurring in gluteal muscles and injection of penicillin during acute illness.

Since 1950 there has been widespread interest in the relation between the occurrence of paralytic poliomyelitis and previous injections of various substances, including antigens, penicillin, and other medications. Most of the numerous articles which have appeared in the American and British literature have concluded that there is a definite relation between the site of paralysis and the site of injection.[6, 7, 8] Injections of immunizing substances within the two months immediately preceding the onset of polio seem to be chiefly implicated. Some authors, however, seem to feel that penicillin injections are also related to the occurrence of paralysis, including

injections given during the few days immediatel preceding the onset of poliomyelitis.[9, 10]

GAMMA GLOBULIN

The results of the experimental use of gamma globulin during the summer of 1952 are presented in a report by William McD. Hammon, et al.[11]

This is a final report on the results of three controlled field trials carried on in the summer of 1952 to evaluate the effectiveness of Red Cross gamma globulin in the prevention of paralytic poliomyelitis. Analysis of the results showed that Red Cross gamma globulin, in an average dose of 0.14 cc. per pound of body weight, gave a highly significant protection against paralytic poliomyelitis. Cases occurring during the first week following the injection of gamma globulin were significantly modified in severity. During the next period of four weeks a high but not complete degree of protection was demonstrated. During the sixth to eighth week after injection the protection appeared to wane, and none was detectable after the eighth week.

The controlled cases who received injections of gelatin in place of gamma globulin were carefully analyzed and no evidence was presented to suggest that inoculation of gelatin had either provoked or localized paralysis.

The authors discussed the relative advantages and disadvantages of gamma globulin as a preventive of paralytic poliomyelitis. Up to the present it is the only available preventive measure against paralytic poliomyelitis. Its use however, is not a panacea for the prevention of paralytic poliomyelitis. First and foremost, the supply of gamma globulin is very limited and the expense per case prevented is colossal. In addition to problems of supply and expense, other drawbacks are the short duration of passive protection; the need for reinjection each time poliomyelitis becomes prevalent in the community; the extremely low incidence of paralytic poliomyelitis; the inability to determine the time of exposure and hence the optimal time to use gamma globulin; susceptible children cannot be distinguished from immune children; protection is not always complete and hypersensitization may occur.

In any disease with less emotional appeal than poliomyelitis, all these considerations would probably prohibit its use. In poliomyelitis its use will be demanded and it will be used. It is estimated that in the next year or two one or more million doses will be used and a relatively small number of cases of paralytic poliomyelitis will be prevented.

RELATIONSHIP OF GAMMA GLOBULIN TO VACCINE

The greatest contribution of these field experiments has been the demonstration that a very low concentration of antibody will protect man. This has been of great value in the work being done in active immunization with poliomyelitis vaccine. Many of the experimental vaccines used in recent years have stimulated in animals the production of more than the amount of antibody now recognized as necessary for protection of man. If these vaccines are similarly effective in children and prove to be free from possible harmful effects, they will be made available for general use. This study will, however, be most time consuming. Because it has been shown from the gamma globulin field trials that antibody level need not be as high as had been expected to protect against paralysis in poliomyelitis, vaccines need contain less virus than had been previously anticipated.

The dosage used in the field experiments, 0.14 cc. per pound, gave protection for 5 to 8 weeks. Blood antibody levels in children fall 50 per cent in three weeks. Doubling the dose will extend protection only three weeks. If protection longer than five weeks is needed, it is suggested that the dose be repeated after five weeks, thus getting protection for 10 to 13 weeks. If a known exposure over a period of only a few days occurred, as in measles, a dose similar to that given for measles prophylaxis might be effective. However, rarely is such exposure recognized for poliomyelitis so the dose used empirically in the field trials—0.14 cc. per pound—seems more practical and reasonable.

It is well established experimentally that even larger doses of gamma globulin will not affect the course of the disease if given after the onset of symptoms, even in the preparalytic phase. It is emphasized that this scarce material must not be wasted in the treatment of poliomyelitis by giving it to children who are already sick.

RESULTS OF THE USE OF GAMMA GLOBULIN IN 1953

The results of the more extensive use of gamma globulin during the summer of 1953 have recently been published.[12] Unlike the evaluation of the program in 1952 as previously outlined, the results of this past summer's large-scale use of gamma globulin were extremely disappointing. Two conclusions may be drawn. Firstly, the administration of gamma globulin in the recommended dosage to familial associates of patients with poliomyelitis had no significant influence on the total number of secondary cases of both nonparalytic and paralytic cases. Secondly, the carefully compiled information as the result of the mass use of gamma globulin in epidemic areas did not yield statistically measurable results. Therefore the committee stated that the value of gamma globulin in community prophylaxis during 1953 has not been demonstrated. On the other hand, they could not say absolutely from their information that the use of gamma

globulin during epidemics produced no effects. This simply means that further controlled studies must be undertaken before any value can be attached to gamma globulin as a prophylactic agent in this disease.

VACCINE

The problem, therefore, of the control of poliomyelitis still remains one of the development of a safe, effective vaccine to establish active immunity in susceptible individuals. Dr. Albert S. Sabin[13] presents an excellent review of the present status and future possibilities of a vaccine for the control of poliomyelitis. Dr. Sabin states that a safe and practical vaccine for active immunization against poliomyelitis is not as yet available but that the possibility of the development of such a vaccine has improved greatly due to new information accumulated over the past five years.

The demonstration that there were only three major immunologic types of polio viruses was the first important discovery. Type 1 (Brunhilde-like) strains were found most regularly responsible for major epidemics.

The most important of the new developments in poliomyelitis research was the demonstration that the viruses may be grown not only in human embryonic and adult non-nerve tissues in vitro, but also that the virus will produce a cytopathogenic change by which the presence of virus can be recognized without having to resort to animal inoculation. Non-nerve tissues in monkeys, especially the kidneys, provide a medium in which all three immunologic types of poliomyelitis virus multiply to a level hitherto unobtained in live monkeys. This new technique opened new opportunities for investigation of the immunologic capacity of purer, more potent, and plentiful preparations of virus.

Sabin feels that there are three approaches to the problem of active immunization: (1) "killed" virus vaccine; (2) immunization with active virus under cover of antibody; (3) an avirulent virus vaccine.

Because of the inherent shortcomings of all types of killed virus vaccines, Sabin feels the ultimate goal for the prevention of poliomyelitis is immunization with living avirulent virus which will confer immunity for many years or for life. At present time Dr. Sabin's laboratory is actively engaged in the investigation of the development of a living avirulent virus which will be safe for human vaccination. Recently he has announced striking developments in this field, and while much study and investigation lies ahead the possibility of an attenuated living viral vaccine seems very great.

Dr. Jonas E. Salk[14] has undertaken extensive studies in the field of active immunization against poliomyelitis by the use of a killed virus vaccine. Salk reported preliminary results of studies in human subjects inoculated with different experimental poliomyelitis vaccines. Virus of each of the three immunologic types were grown in cultures of monkey testicular tissue or monkey kidney tissue. The virus was rendered non-infectious by treatment with formaldehyde and was tested on monkeys prior to human injections.

Two types of vaccine were tested—an aqueous suspension and a water-in-oil emulsion vaccine. The aqueous vaccine, containing only Type 2 virus, was introduced intradermally. The water-in-oil emulsion vaccine contained all three types of poliomyelitis virus and was introduced intramuscularly. Levels of antibody induced by both types of vaccine compared favorably with those produced by the disease and the antibody level produced by the vaccines persisted without signs of decline for the period of study up to the time of this report—4½ months after the start of the experiment.

Salk warns that though the results obtained in these studies may be regarded as encouraging, they must not be interpreted to indicate that a practical vaccine is now at hand. Further experimentation is necessary to reproduce with certainty the results obtained in this study. These experiments take a great deal of time because of the great importance of the safety factors. In the preparation and study of each new batch of experimental vaccine, considerable time is required to ensure the safety of vaccines prior to human inoculation.

Large field trials using the Salk vaccine are now getting under way to test the effectiveness of the vaccine during the coming polio season.

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Lateral Ventral Hernia in the Rectus Sheath*

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A PROGRESSIVELY increasing number of reports of lateral ventral or Spigelian hernia in both the European and American literature has appeared during the past few years. However, there is no recorded instance of spontaneous hernia in the rectus sheath. In fact Watson[1] states that "hernia in the sheath of the rectus muscle is very rare and always follows rupture of the rectus muscle and its fascia."

In the following two case presenations there was no history of such antecedent rupture or injury. In both patients the hernia involved the right compartment of the rectus muscle with the hernial ring situated in the center of the posterior rectus sheath, well below the umbilicus, and with a branch of the deep epigastric artery accompanying the sac and preperitoneal lipoma. The linea semicircularis or semilunar fold of Douglas entered into the formation of the upper thick margin of the hernial orifice, precipitating a Richter's hernia by engaging a portion of the anti-mesenteric border of the ileum in the first instance, but seemed lower and not to be directly involved in the second.

The third case report is one of left sided Spigelian hernia following a sudden straining effort.

CASE REPORTS

Case 1. (Referred by Dr. J. Saltzman.) Mrs. —, a 64 year old white widow was admitted to St. Alexis Hospital, Cleveland, on November 4, 1949 complaining of pain and tenderness in the right lower quadrant with a palpable mass. She had been aware of the presence of this tumor for the past 7 months, but pain and tenderness had been recurring at irregular intervals only, for the last 6 months.

Three days prior to admission she was seized with intense pain over the mass, radiating to the epigastrium associated with nausea, vomiting and the absence of bowel movements. Patient had one full term pregnancy and no previous operations or injuries.

Physical Examination: Admission temperature was 99.6 F., pulse 112, respiration 26. Blood pressure 122/78. Hemoglobin 11.4 grams; red blood cells 3,620,000; white blood cells 6700; sedimentation rate 46; blood chlorides 450; blood protein 5.8 grams. The abdomen was distended and there was a tender fixed mass in the right lower quadrant about two inches in diameter. Roentgenological examination revealed distended loops of small intestine indicating partial obstruction of the terminal ileum at the region of the tumor mass, which did not appear to arise from the colon.

Diagnosis: A tentative diagnosis of partial intestinal obstruction was made probably due to carcinoma of the ileo-cecal valve. The post-operative diagnosis was Richter's hernia in the rectus sheath.

Operation: In surgery under spinal anaesthesia, a right pararectus incision was made and a hernial sac with preperitoneal lipoma was found 1½ inches long and ½ inch in diameter. It had entered the middle of the posterior rectus sheath, one inch above and medial to the internal abdominal ring, along with the deep epigastric vessels. The summit of the linea semicircularis helped form the upper thick margin of the hernial ring whose diameter was ½ inch. The sac, with thickened and inflamed walls ascended along the lateral margin of the rectus muscle, having firmly fixed itself to the muscle and its sheath. It contained hemorrhagic fluid, incarcerated adherent omentum and a small portion of the circumference of the free border of the terminal ileum, which upon release from the constriction resembled a small diverticulum of the intestinal wall.

The omentum was resected between sutures and the purple area of the ileum was treated with warm compresses until normal color returned, permitting reposition into the abdomen. The sac was closed with transfixion suture of fine silk and the defect in the sheath was imbricated by interrupted mattress sutures of silk. The anterior rectus sheath was approximated by interrupted figure of eight silk.

Convalescence was rapid and uneventful with release of the patient on the 11th day.

Follow-Up: Examination three years later revealed no recurrence.

Case 2. The patient, a 57 year old white nulliparous housewife had a tumor in the right lower abdomen for 25 years which had recently undergone an increase in size and was associated with nausea and emesis for the past week. She complained of a burning pain in the epigastrium radiating to the mass in the lower abdomen. Vomiting had been persistent for the past four days with no bowel movement for three days.

Physical Examination: On the day of admission, September 21, 1951, the temperature was 99.F., pulse 100, respirations 24; blood pressure 152/100, hemoglobin 12.5 grams; red blood cells 3,900,000; white blood cells 6100 and sedimentation rate 38. There was a tender slightly movable firm mass in the region of the lower third of the right rectus muscle about 3½ inches in diameter. The abdomen was distended and the roentgenogram revealed almost complete obstruction of the terminal ileum near the cecum.

Intravenous fluids were given and a Miller-Abbott tube was introduced. The history, physical

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examination and x-ray findings suggested an incarcerated lateral ventral hernia, but with the facts and experience acquired in the previous case, a diagnosis of incarcerated hernia in the rectus sheath was made and the patient was prepared for surgery.

Operation: Under spinal anaesthesia, a right pararectus type of incision was made over the most prominent portion of the mass and a long hernial sac with adipose cap on its distal extremity was discovered in the rectus sheath, accompanied by branches of the deep epigastric vessels. The muscle fibers were separated by the sac which presented under the anterior rectus sheath and which had produced a marked thinning and bulging of the sheath in this area. The sac was possessed of a thick wall which was tense and measured 4 inches in length and ¾ inch in diameter. It contained bloody fluid, adherent omentum and a knuckle of dusky edematous bowel, or more precisely, the terminal ileum.

The opening through the center of the posterior rectus sheath was ½ inch in diameter and about 2 inches below the level of the umbilicus. The semicircular line was situated an inch below the hernial ring. The ring was enlarged by incising the sheath proximally and distally, and the omentum was excised between sutures; proximal stump was reduced and warm moist tapes were applied to the freed ileal loop until peristalsis and normal color returned, at which time it was replaced in the abdomen.

The neck of the sac was closed by a transfixion suture of fine silk and the hiatus was repaired by overlapping the posterior sheath with interrupted mattress sutures of silk. Anterior rectus sheath was approximated by interrupted figure of eight silk.

Recovery was smooth and patient was discharged on the 9th postoperative day.

Follow-Up: Examination one year later showed no recurrence.

Case 3. The patient, a white shipping clerk, 58 years old, following a sudden strain, experienced a sharp burning pain in his left side and developed a tender mass in the left semilunar line 2 inches in diameter between the umbilicus and the pubes. He was seen an hour later by his factory physician who told him he had a hematoma of the abdominal wall as a result of the strain and advised him to return home and apply hot compresses. The pain increased in severity and was associated with persistent nausea and emesis so that patient requested hospitalization. He was admitted on the following day and was prepared for operation.

Diagnosis: A strangulated ventral lateral or Spigelian hernia was diagnosed.

Operation: A transverse incision was made over the mass and the aponeurosis of the external oblique was split in the direction of its fibers; the hernial sac was dissected free, opened and the strangulated loop of small bowel, 2½ inches in length, which appeared bloodless and necrotic was freed. Warm moist tapes were applied to the bluish-purple intestine until normal color and peristalsis returned; it was then replaced in the abdomen.

The opening in the semilunar line coincided with the semicircular line of Douglas, which apparently formed the thick upper margin of the ring. The deep epigastric vessels were situated medial to the sac. The neck of the sac was closed by fine silk transfixion suture and the redundant portion was excised, stump was reduced into the perperitoneal space and the transversalis fascia was repaired by interrupted silk sutures; the internal oblique muscle and external oblique aponeurosis were sutured in layers with interrupted unabsorbable sutures.

Follow-Up: Recovery was uneventful and examination 3 years later revealed absence of recurrence.

DISCUSSION

For a better approach to the etiology and treatment of spontaneous lateral ventral hernia, a brief description of the formation and relations of the rectus sheath may prove helpful. The sheath of the rectus is a strong, incomplete fibrous compartment formed by the aponeuroses of the three flat abdominal muscles which crisscross in the midline to form the linea alba. The composition of the sheath differs in its upper and lower portions. In its upper three-fourths the rectus muscle has a complete covering, formed in front by the aponeurosis of the external oblique and the anterior leaf of the aponeurosis of the internal oblique, and behind by the aponeurosis of the transversus abdominis and the posterior leaf of the internal oblique aponeurosis.

In the lower fourth the aponeuroses of the three muscles pass entirely in front of the rectus, so that the inferior extent is devoid of a posterior fibrous investment. The posterior aponeurotic layer terminates in the linea semicircularis or semilunar fold of Douglas, which is fused to the underlying transversalis fascia. The extremities of the semicircular line pass downward as pillars to insert into the public bone.

McVay and Anson[2] in studying the composition of the rectus sheath found that the arch of the semilunar fold may be situated at any point between the umbilicus and the pubic crest, thus accounting for the various levels at which Spigelian herniae may be found.

The lateral margin of each rectus muscle is indicated on the anterior abdominal wall by a vertical groove or depression, the linea semilunaris or Spigel's line. This represents the line of transition between the muscle bundles and the aponeurosis of the transversus abdominis. It begins at the pubic tubercle and passes upward midway between the umbilicus and the anterior superior spine of the ilium, to its attachment to the tip of the ninth costal cartilage. As mentioned previously, the aponeurosis of the internal oblique splits along this line to inclose the rectus above the semicircular line only, below this it passes anteriorly.

Lateral ventral or Spigelian herniae usually emerge at the junction of the semilunar with the semicircular line, with the latter entering into the formation of the hernial ring as in Case 3.

The rectus sheath is pierced at different levels

by the last six intercostal and four lumbar arteries and nerves, the superior and inferior epigastric, and deep circumflex iliac arteries. The inferior epigastric artery and vein ascend superiorly and medially toward the umbilicus, pierce the transversalis fascia and pass in front of the semicircular line to enter the rectus compartment. This vascular opening is important from the standpoint of weakness and potential hernia site according to the theory of Cooper[3], and as found in Cases 1, and 2.

THEORIES

Cooper believed that spontaneous lateral ventral herniae owed their origin to the presence of minute vascular openings through the fascia and aponeuroses.

Cloquet[4] theorized that the less common lateral ventral herniae were in fact accounted for by the protrusion of a preperitoneal cap of adipose tissue through the fascial hiatus of a vascular or neural foramen, which later drew a funnel of peritoneum after it forming a true hernia. This tended to support or reinforce the validity of the Cooper theory which was first promulgated in 1804. Further support is given this theory by the report of Wakeley and Childs[5].

Di Molfetta[6] disagrees with the anatomical treatises and maintains that the posterior rectus sheath is not deficient below the fold of Douglas as a result of the passing anteriorly of all the layers of the aponeuroses, but that instead they pass dorsally as in the upper three-fourths and undergo a gradual thinning out and fading inferiorly, leaving the dorsal surface of the rectus muscle unprotected in the suprapubic area. Thus hernia may arise in the posterior rectus sheath as a direct result of this thinning and fraying to present anteriorly under the anterior rectus sheath, or may subsequently point toward the semilunar line and then present as a Spigelian hernia. However, he offers no clinical proof to substantiate his alleged findings.

Maldevelopment of the abdominal wall frequently may be responsible, as in a case described by Paul and Hill[7], in which a large portion of the abdominal contents passed through a congenital deficiency in the linea semilunaris of a 10 year old girl. In addition to the congenital anatomical anomalies or defects, factors which increase intra-abdominal pressure or tension are definitely concerned in the etiology of spontaneous lateral ventral hernia, of which, hernia in the rectus sheath is a variety. Foremost among these factors are: multiple pregnancies, obesity, especially if followed by marked weight loss, ascites, chronic cough and muscular effort.

Although herniae in the rectus sheath and the semilunar line are rare, they are comparatively frequently associated with strangulation and Richter's type of hernia owing to the smallness of the sac and rigidity of the hernial orifice, which rarely exceeds ¾ inch in diameter. The hernial ring is usually a sharply defined hiatus or defect in the posterior rectus sheath in the case of rectus hernia or at the junction of the semilunar and semicircular lines in Spigelian hernia.

The sac consists of peritoneum and is often preceded by a lipomatous mass of preperitoneal adipose tissue. Its contents usually comprise adherent omentum and small bowel. The hernial sac lies either under the anterior rectus sheath or the aponeurosis of the external oblique, depending upon the type of hernia, with the fascial structures thinned out and bulging as a result of the constant pressure. So long as the omentum, only, occupies the sac the individual may go about his work in relative comfort and be asymptomatic, even knowing that he has a "mass in the side," until such time as a loop of intestine becomes engaged in the hernial ring,—then with dramatic suddenness, the cramping pain, nausea, vomiting and obstipation herald the onset of strangulation and demand immediate surgical intervention. On the other hand the palpable mass with change in bowel habit associated with signs of intestinal obstruction may occasionally simulate a carcinoma of the colon, unless the possibility of this rare type of hernia is kept constantly in mind.

TREATMENT

The only rational treatment for spontaneous lateral ventral hernia is early surgical repair. An incision is made over the most prominent portion of the mass and the sac is dissected free from the surrounding muscular and fascial layers along with the preperitoneal lipoma. The sac is opened, neck enlarged to permit inspection and reduction of contents if viable. Adherent omentum is resected between sutures and proximal stump replaced. Non-viable intestine is resected followed by anastomosis and replacement in the abdomen. The neck of the sac is transfixed with fine silk and obliterated, followed by resection of the redundant portion. A layer repair of the abdominal wall is then carried out employing unabsorbable interrupted sutures and using the overlap method where weakness of the wall dictates.

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Epidermolysis Bullosa: A Case Report

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EPIDERMOLYSIS bullosa, a chronic disease of skin and mucous membranes, was first described by Fox[1] in 1879 and given its present name by Koebner[2] in 1886. The disease process is of unknown etiology and is manifested by the formation of multiple vesicles and bullae. The following three varieties have been described:[2, 3, 4]

Simple form: The lesions are usually superficial and acentrolytic. Healing occurs without prominent scarring. This form appears in childhood, is usually self-limited, and disappears completely at puberty. Mucous membranes and nails are only rarely involved.

Dystrophic form: The lesions are epidermolytic, more prominent on mucous membranes and nails, and often contain hemorrhagic fluid. Healing is marked by scarring, pigmentation, and skin atrophy. This form typically appears in childhood and usually persists for life.

Letalis form: The lesions resemble closely those of the dystrophic form but are present at birth or shortly thereafter. This form of the disease is rapidly progressive and terminates in death in a matter of a few months.

CASE REPORT

The patient, female infant, —, was born at Good Samaritan Hospital, Cincinnati, Ohio, on September 18, 1952. The pregnancy, labor and delivery were uncomplicated. There was no history of maternal illness before or during this pregnancy. The family history was non-contributory. One sibling is living and well.

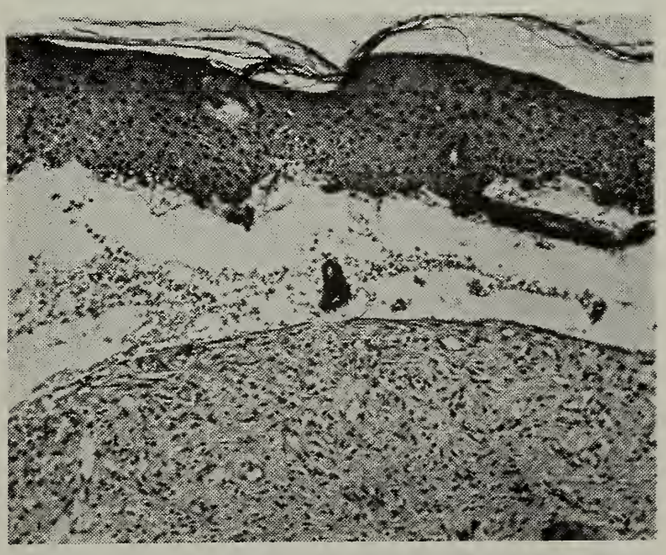
The infant, which weighed 8 pounds, 1 ounce, was transferred to the pediatric service on the day of birth because of the presence of almost complete denudation of the skin of both feet and ankles. Within hours vesicular and bullous lesions appeared on the face, anterior chest, thighs, buttocks, external genitalia, lower legs and the dorsal surfaces of both hands. The bullae ranged in size from 1 to 5 cm. and contained clear amber fluid. Erythematous patches of varying sizes surrounded the lesions. Physical examination was otherwise negative.

Laboratory Data: A complete blood count reported on the day of birth revealed an erythrocyte count of 4.41 millions, hemoglobin of 13.5 grams and a leukocyte count of 16,050 with a normal differential. A culture of the vesicular fluid yielded E. coli and H. Staphylococcus aureus. A routine urinalysis and test for urine porphyrins were negative. The Kahn test was negative.

Hospital Course: Therapy included a 14-day trial of cortisone which yielded no appreciable improvement in the lesions. Combined penicillin and streptomycin were then given parenterally, and penicillin ointment locally with some improvement. Because the infant nursed very poorly for the first week after birth a standard evaporated milk formula was given through an indwelling polyethylene catheter. Good nursing care and subsequent avoidance of trauma to the skin and mucous membranes proved to be the most valuable adjunct to the entire therapeutic regime.

One month after birth the erythocytes had dropped to 2.50 million and the hemoglobin to 9.5 grams. New crops of lesions continued to appear. At that time small transfusions of whole blood were given in an attempt to improve the infant's general condition. The erythrocytes then rose to 3.13 million and the hemoglobin to 11 grams. The temperature remained normal throughout the first admission. At the parents' insistence, the infant was discharged to their care on November 25, 1952. Weight at the time of discharge was 8 pounds and 14 ounces.

Hospital Readmission: The infant was readmitted to the pediatric service at three months of age for further observation and evaluation. Weight on this admission was 10 pounds, 5½ ounces. The general developmental pattern was fair. On the tongue, gums and lips were found very vascular eroded areas .5 to 1 cm. in circumference. Along the frenulum was noted a small hemangioma. Over the hard and soft palate



Skin biopsy: Infant, —, age 3 months. The epidermis is separated from the corium along the entire extent of the specimen by a rather narrow irregular space which contains only erythrocytes. The corium bounding this vesicle displays fibrosis capillary proliferation and mild chronic inflammation. Superficially the vesicle is bordered by the basal layer of the epidermis. Elastic tissue stains reveal a pronounced deficiency of elastic tissue in the corium. Diagnosis: Epidermolysis Bullosa.

The Authors

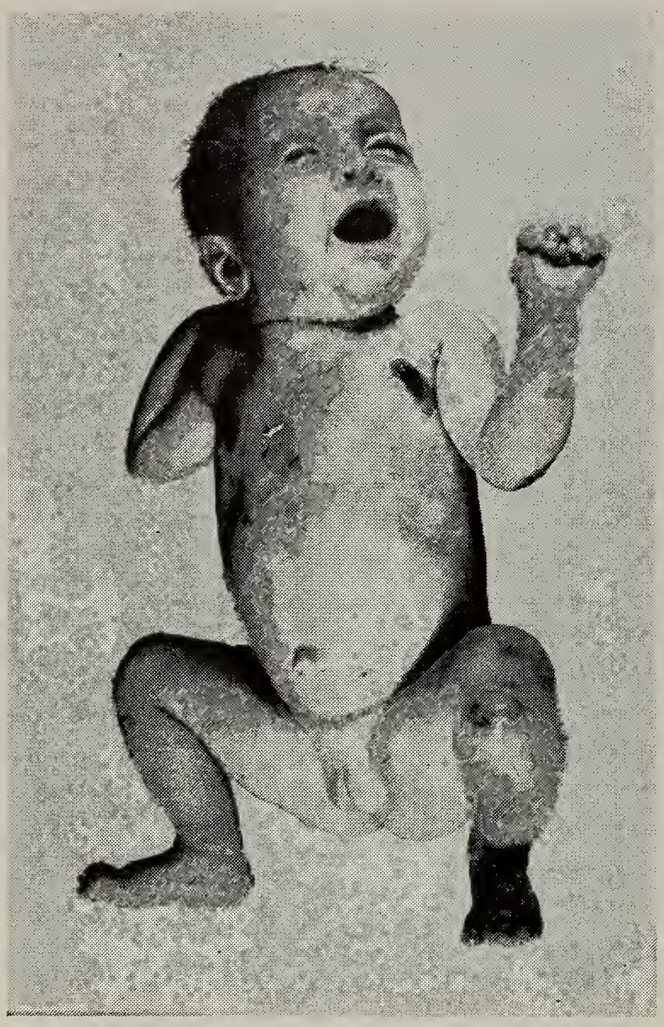
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Submitted May 18, 1953.

were discrete gray-white pseudomembranous areas.

Scattered over the skin of the entire body but particularly over the extremities were areas of cicatrization, interposed between the typical vesicular and bullous areas which were in various stages of development. A diffuse alopecia was also present. Punched-out ulcers were present over the left great toe and the left great toenail was absent. After gently stroking the skin with one's



Infant, —, age 3 months. Photograph illustrating many of the lesions typical of Epidermolysis Bullosa.

finger, vesicular and bullous areas developed within minutes. A similar reaction followed the intracutaneous injection of .1 cc of physiologic saline solution.

Laboratory work on this admission included a series of routine urinalyses and complete blood counts which were all within normal limits. The bleeding time was 1 minute 10 seconds, and the clotting time 1 minute 3 seconds. Porphyrinuria was again absent. The bone marrow examination was reported as normal. Interestingly enough, 75 per cent of a calculated amount of Congo Red dye had disappeared from the peripheral blood one hour after injection.

Diagnosis: A skin biopsy verified the diagnosis of epidermolysis bullosa. The infant was then again discharged from the hospital to be followed at frequent intervals.

SUMMARY AND CONCLUSIONS

A typical case of epidermolysis bullosa in a full term white female newborn has been described. Despite the progressive course of the disease, the general developmental pattern at three months of age is fairly normal. The most advantageous therapy appears to be good nursing care and the prophylactic use of antibiotics and dietary supplements. A trial of cortisone did not significantly alter the course of the disease. A skin biopsy illustrated the often reported deficiency of elastic tissue which must contribute greatly to the pathogenesis.[5] The disappearance of 75 per cent of a calculated amount of Congo Red dye from the blood in one hour tends to support Marchionini's recently expressed opinion regarding the association of amyloidosis and epidermolysis bullosa.[6, 7] The authors prefer to think of the letalis form of the disease as a fulminating variant of the dystrophic type present in the neonatal period rather than as one of three distinct subtypes.

Acknowledgment: Our sincere appreciation is expressed to Drs. Roy L. Kile, William T. Collins, and Fernard R. Siegel for their assistance in the preparation of this manuscript.

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Diesel Engine Dermatitis Control

With respect to the railroad industry, from all statistics that are available, it would appear that prior to the advent of the diesel locomotive the incident of occupational dermatitis was so low as to be a negligible factor, and it was not until the diesel locomotive came into extensive use that it assumed any proportions. However, with those railroads that went into an extensive dieselization program during and immediately following the war, the number of occupational dermatitis cases climbed quite markedly.

This increase was due, of course, to the tremendous increase in the use of petroleum products and derivatives incidental to the operation and maintenance of the diesel locomotive.—Robert Plunkett, Great Northern Railway, Saint Paul, Minn.: *Minnesota Medicine*, 37:336, May, 1954.

Pathology and Psychiatry

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Etenim omnes artes quae ad humanitatem pertinent, habent quoddam commune vinculum, et quasi cognatione quadam inter se continentur.

CICERO—*Pro Archia, 1:2*

THE train of thought leading to this paper was set in motion by two circumstances. One of these was a series of informal discussions with medical colleagues, arising from a previous communication[1] on the relationship between surgery and psychiatry. Due to many points of similarity between surgery and pathology, it seemed logical to extend certain of the concepts advanced regarding the surgical-psychiatric liaison to the relationships between pathology and psychiatry.

The other circumstance was a dream presented recently by a patient in intensive psychotherapy. The dream dealt with the relationship between the patient and his doctor, and represented the latter as a white-coated man in a laboratory, peering through a microscope at unidentifiable material obtained from the patient. Dreams of this type are by no means rare and suggest—in addition to certain specific meanings, varying with the individual—an intuitive perception on the part of patients of some element common to the two disciplines.

Such patients see the similarities of the two specialties more clearly than many physicians who would say that these disciplines, being at opposite poles from one another, are essentially unrelated. Psychiatry, they would say, is occupied with the study of the personality, whereas pathology is not at all occupied with personality factors.

Now there is no question at all about there being deep and significant differences both in the subject matter and the orientation of the two disciplines. Nevertheless, further reflection indicates that the above statement of unrelatedness is not the whole truth of the matter. On the one hand, *personality*, in its broadest scientific sense, includes numerous anatomical and (physical) pathological factors. On the other, the modern concept of pathology[2] as a dynamic study of disease processes, in which one reasons backward from certain demonstrable effects to their causes and forward to still other effects, has numerous possible points of contact with emotional factors in patients. In addition the pathologist as a person and as a physician not infrequently has contacts with patients, students, and professional colleagues in which emotional factors may play a significant role.

As an introductory note, it is worthy of mention that many of the giants in the field of psychiatry have had, at the outset of their careers, extensive backgrounds in the field of pathology or in closely allied fields. Adolf Meyer, for example, preeminent in American psychiatry, was originally, by training and profession, a pathologist. Sigmund Freud, psychiatry's greatest genius, had a broad laboratory background and made several neuroanatomical and neuropathological contributions antedating his psychiatric ones. Charcot, one of Freud's teachers, and the author of unexcelled descriptions of hysterical phenomena, had an extensive orientation in pathology, holding for a long time the chair of pathological anatomy in Paris. The list is a considerable one, having, for example, as an early representative Thomas Willis, a pioneer in neuroanatomy and neuropathology, who was also a serious student of psychiatric phenomena.

It is also—and increasingly—true that in recent years a number of distinguished psychiatrists have made serious contributions to pathology, in the broad sense of the above definition. The nature of these contributions will be subsequently referred to, but it should be mentioned here that in the forefront of this work are such men as Franz Alexander and his associates at the Chicago Institute for Psychoanalysis and Harold Wolff and his co-workers at Cornell.

A MAJOR COMMON ELEMENT

The more one considers the matter, the more forcefully does this conclusion assert itself: *In their fundamental orientations the two disciplines, pathology and psychiatry, have as a major common element the drive to go as deeply as possible beyond surface phenomena, the signs and symptoms presented by the patient, in the search for ultimate causation.* This urge is reflected in technique, but it is more than just

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a matter of technique; it is an aspect of the goal, itself. One practical consequence is that research is more an *integral* part of practice in pathology and psychiatry than in many, perhaps in most, other medical specialties.* It is true that psyschiatry has a major therapeutic mission, whereas pathology's role in this sphere is essentially confined to obtaining data to guide the therapy of other specialties, yet both psychiatry and pathology devote relatively a very large portion of their time to trying to understand the problems set before them; they are, in a large measure, *reflective disciplines.*

Moreover, the specific research interests of pathology and psychiatry, far from being in opposition to one another, are in certain respects almost uniquely complementary in the task of obtaining a comprehensive view of the human organism affected by illness. On one aspect of its progress each discipline is actually groping its way toward the other.

The situation resembles that in which two parties of men begin digging the same tunnel, starting from opposite ends. The probability of an increasingly broad meeting-ground is implied in two now generally accepted principles. The first is that in the organism every function involves physical changes. (And one of the best definitions of *mind* is Massermann's purely functional one: "Mind is the body in action.") The second is that physical changes are regularly accompanied or followed by functional changes ("mental" changes, in the broadest sense).

CONTRIBUTIONS OF PATHOLOGY

The direct contributions of pathology to psychiatry over the years have been numerous. Merely to list them would be beyond the scope of this paper, but, as an example, the elucidation of paresis may be used. Here the primary treatment of a psychiatric condition rests squarely upon the efforts of pathologists and workers in closely allied fields: Bayle, Salomon, Alzheimer (1904), Widal, Schaudinn (1905), Lange, Wassermann (1906), Ranke, and Noguchi and Moore (1913).

Paresis also provides a clear example of one of the ways in which psychiatric research (Ferenczi and Hollos, Schilder) complements pathological research. Many of the specific symptoms of paretics, inexplicable on the basis of the various sites, types, and degrees of tissue damage alone, have become comprehensible with the introduction of psychiatric concepts. Such symptoms are to be regarded as due to (1) mobilization and intensification of pre-existing emotional conflicts (perhaps largely unconscious) in the face of personality weakness resulting from the organic damage and (2) attempts at erection of personality defenses aroused by the vague perception of the loss of mental capacity with attendant anxiety.

There is no reason to suspect that the direct contributions of pathology in the broad sense to psychiatry are at an end. With the constantly increasing development and refinement of techniques of investigation it appears altogether reasonable to expect that further light will be shed by pathology on certain aspects of disease processes of interest to psychiatry. Reference is intended here not to the wearisome dispute, "psychogenic versus somatogenic," still maintained in some quarters, but to certain more refined and specific questions, such as the nature of the physical components in processes or states now described in purely psychological terms, such as "erotization" of a part of the body or the "restorative" effect of electroshock treatment.

CONTRIBUTIONS OF PSYCHIATRY

It is principally through the recent developments in psychosomatic medicine that psychiatry is paying its debt to pathology. The most useful general concept[3] in this connection is the one that unconscious emotional conflicts (which, of course, have their physical concomitants at a biochemical and electrical level) can produce functional changes (in a grosser sense) and that these functional changes, if long maintained, can produce irreversible structural changes.

The implications of this concept are so numerous and the problems to be solved in its research applications are so great that an understandably (and perhaps desirably) large amount of controversy exists with regard to many areas under consideration. Yet it is already true that in certain conditions—for example, peptic ulcer, essential hypertension, and certain cases of chronic bronchial asthma—psychiatry has furnished pathology with valuable information about early stages in pathogenesis. It is, to return to the analogy, as if, in these areas the two groups of tunnel-diggers have begun to effect a junction, and a ray of light can shine through the entire length of the tunnel.

In addition to the liaison channels afforded by the direct clinical and research contributions pathology and psychiatry make to one another, there exists another area in which the two disciplines could benefit by a freer exchange of ideas, the area of principles and techniques. Psychiatry is sometimes called the least scientific of medical specialties; pathology, the most scientific. Without subscribing to a flat generalization of this sort, one may nevertheless draw the reasonable inference that certain research techniques or principles of pathology should be given further consideration by psychiatry. A full and fair statement of such principles with illustrations of their application could better be given

*Those basic medical sciences, such as anatomy, physiology, and biochemistry, which can largely be pursued apart from a clinical setting, are not considered to be included in this statement.

by a pathologist than by the writer, but the points to be considered would include a careful development of the use of controls, a further integration of clinical and experimental material, the isolation of as many variables as possible in research work, and a more comprehensive understanding of statistical validation.

On the other hand certain psychiatric principles can be of real value to the pathologist in a number of situations. As indicated earlier these situations are to be found among those in which the pathologist is called on to function in an interpersonal relationship (a matter of increasing frequency), and they may be grouped in several categories.

1. Teaching medical students (who are having their first contact with the study of disease processes).
2. Contacts with patients:
   (a) at the bedside (as in bone-marrow or other biopsies);
   (b) in the office or laboratory (as in the obtaining of certain other specimens, or in the supervision of BMR or other metabolic determination).
3. Contacts with the relatives of patients (in connection with laboratory work or autopsy procedure).
4. Certain situations involving professional colleagues (as the clinicopathological conference in which the pathologist is in the somewhat unique position of having to function as an equal among equals and yet of having to pronounce the final, authoritative answer).

All of these situations contain a common element, namely, the possibility of arousal in the students, patients, etc., of disturbing feelings (chiefly anxiety, but also fear, resentment, and guilt on occasion). It is not meant to imply that the intensity of such feelings frequently reaches the point of causing serious distress or hinderance to the job at hand, but to call attention to the fact that the potentiality for such occurrences exists and that the incidence and degree of such occurrences can be reduced by the utilization of psychiatric principles and techniques.

It is beyond the scope of this paper to discuss in specific detail the emotional implications of these various situations, but brief consideration of one of them appears to be in order, by way of illustration. For its relative simplicity (and recognizing its infrequency) the situation is chosen in which the pathologist has contact with a patient's next-of-kin in connection with an autopsy and in which these relatives exhibit strong negative feelings toward the procedure and perhaps toward the pathologist (as well as toward the clinician and the hospital).

The first point to be recognized is that the emotional factors motivating the relatives in such a situation are often largely below the level of their conscious awareness, and may therefore be quite unrealistic and illogical. A second consideration is that among such factors guilt feelings toward the deceased are apt to be prominent.

Such recognition involves several implications. For example, hostile feelings in the doctor are less easily aroused, since he realizes that the family's resistance to the procedure or criticism after it has been performed has fundamentally little or nothing to do with himself. Furthermore, in dealing with members of the family—either to help obtain their permission for the autopsy or to answer irate criticism afterward—he will attempt to understand their emotional position. Accordingly the doctor will not rely alone (and sometimes not even primarily) upon logical arguments in speaking with relatives, but upon acknowledgement of and to some extent meeting their emotional needs (as in offering reassurance against guilt feelings).

SUMMARY

The widespread view that pathology and psychiatry have little or nothing in common is seriously questioned. Numerous historical links are reviewed. The drive to penetrate deeply beyond surface phenomena of disease in the search for ultimate causation is pointed out as a common element in the basic orientations of the two disciplines.

A major possibility for a productive relationship is thought to be afforded by the exchange of clinical and research data to form a comprehensive view of the human organism affected by disease. In addition each discipline is held to gain by consideration of certain principles and techniques of the other.

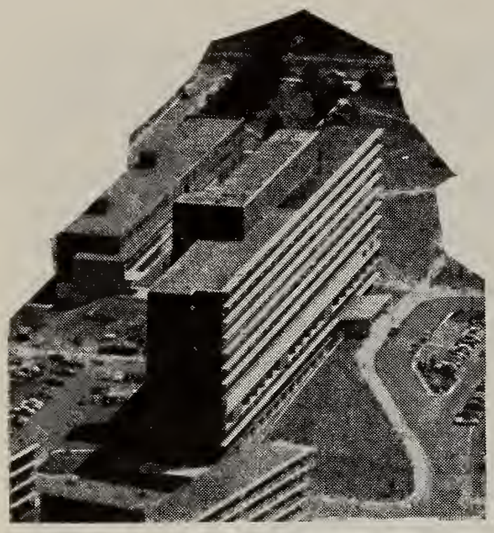
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Toxic Vertigo

Toxic vertigo, as from quinine, neomycin, or streptomycin, may simulate in all details the Ménière's symptom complex except that the vertigo is usually not sudden but gradual in onset and chronic. Our chief interest is to recognize this possibility from our history and to differentiate toxic vertigo from the infectious forms. Salicylates, tridione,® and dilantin® are drugs in addition to those previously mentioned which are most frequently the offenders in this regard.

Alcohol, excessive tobacco smoking, and chronic carbon monoxide poisoning are also causes of toxic vertigo which may be overlooked.—Vince Moseley, M. D., Charleston, S. C.: *J. South Carolina M. A.*, 50:95, April, 1954.



A Case Record

From The University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Burr M. Hathaway, M. D., President

Presented by B. K. Wiseman, M. D., and Emmerich von Haam, M.D. Edited by E. von Haam

PRESENTATION OF CASE

THIS 56 year old white female was admitted to the University Hospital with the chief complaint of enlargement of the spleen over the past eight to ten years. Approximately 10 years previous to her admission the patient was hospitalized at another hospital for a gallstone attack and at that time was found to suffer from an anemia which was considered to be of hemolytic type. The liver and spleen were found to be slightly enlarged. The patient was placed on liver extract and iron medication, which therapy was continued until two years ago. At that time the patient was started on folic acid therapy.

For the past year the patient had experienced slowly increasing fatigue with exertional dyspnea. She did not suffer from orthopnea or palpitation of the heart. Her spleen slowly enlarged over the past 10 years but in the last year this increase was much more noticeable. Four years ago the patient first experienced pains in the region of her spleen and since then had had such pains intermittently. Bone marrow studies done at other hospitals gave inconclusive results but because of the many unsatisfactory biopsies the bone marrow was considered to be fibrosed. The patient had never required blood transfusions.

Six months before her admission to University Hospital the patient had had episodes of epistaxis and easy bruising; occasionally she suffered from pedal edema. For the past year her abdomen had been slightly swollen; this, however, was relieved by the administration of mercurial diuretics. Occasionally she experienced nausea and vomiting. Over the 10 year period she had lost 45 pounds in weight and in the past two years she had lost 25 pounds.

The family history revealed that one sister had died at the age of 65 with carcinoma of the ovary, a second sister had died at the age of 63 with coronary occlusion.

Physical Examination: On admission the patient's blood pressure was 170/90, her temperature 99° F., her pulse 90 and her respirations 28. She was a poorly nourished, poorly developed white female who appeared chronically ill. The veins over her chest and abdominal wall were distended and her cheeks showed vascular spiders. The skin was atrophic and there was little subcutaneous fat. The cervical, right axillary and left epitrochlear nodes were slightly enlarged. The patient's tongue was smooth, red and beefy. The veins and arteries in her neck pulsated. Her breasts were atrophic.

There was moderate cardiac enlargement. A systolic murmur was heard over the pulmonic area and the second pulmonic sound was markedly accentuated and much louder than the second aortic sound. Hyperresonance was noticeable over the right lung base posteriorly, with a decrease in the transmission of breath sounds.

The liver and spleen were markedly enlarged; the right liver lobe was palpable below the right iliac crest, the left lobe palpable far below the xiphoid process, and the spleen reached below the left iliac crest. Her legs showed two degrees of pitting edema. The remainder of the physical examination including her neural reflexes was not remarkable.

Laboratory Data: On admission her total white blood count was 58,000 with a differential count of 67 per cent neutrophils, 2 per cent basophils, 2 per cent eosinophils, 13 per cent myelocytes C, 1 per cent myelocytes B and 6 per cent myeloblasts. Her total red blood count was 4.82 mil. with 14.4 per cent reticulocytes; her hemoglobin was 10.5 Gm.; the hematocrit was 38 per cent; the platelets numbered 1,803,000. The sedimentation rate was .2 mm. per min. and 17 mm. in one hour. Her blood count varied little during her short hospital stay.

The admission urine examination revealed 100 mg. of albumin, 5 to 7 white blood cells and 2 to 3 red blood cells per high power field and

a specific gravity of 1.011. Her total serum proteins were 5.42 Gm. with 4.45 Gm. albumin and .97 Gm. globulin; the van den Bergh reaction was direct .15 and indirect .25 mg.; the thymol turbidity was 5 degrees; the prothrombin content was 37 per cent; the serum phosphorus was 9 mg., the alkaline phosphatase 9 units. Her fasting blood sugar was 87 mg. Her blood urea nitrogen at admission was 88 mg. and rose three days later to 101 mg.

The phenolsulfonphthalein test of her kidney function revealed 5 per cent excretion of the dye during the first hour and less than 5 per cent during the second hour. The arm-to-tongue circulation time was 20 sec., the arm-to-lung circulation time 15 sec. The vital capacity of her lungs was 2.2 liters. An electrocardiogram revealed nothing definitely abnormal except a slight prolongation of the interventricular conduction time.

X-RAY FINDINGS

X-ray examination of her chest revealed a transverse diameter of her heart which was 50 per cent greater than considered normal for the patient's height and weight. The lung fields showed congestion with a tendency toward pronounced basal markings. The liver and spleen shadows were markedly enlarged. All osseous structures in the vertebral spine showed an irregular sclerotic mottling reminiscent of sclerosing tumor. The peritoneal cavity contained some fluid. Round calcifications suggestive of stones were found in the gallbladder or kidney region.

Hospital Course: The cardiological consultant expressed the opinion that the patient suffered from an acute dilatation of the heart with right heart failure and a possible relative tricuspid insufficiency. He strongly advised against any surgery and upon his recommendation the patient was placed on digitalis (purodigin®) and ammonium chloride. She received paregoric for her loose stools. For several days she was fairly comfortable, sat in a wheel chair and showed good appetite. During her fourth hospital day she became weak and depressed. The following night she showed marked exertional dyspnea and was scarcely able to get on the bedpan. In the morning of her sixth hospital day she stated that her legs and hands felt numb. She refused breakfast, became cold and clammy and expired quietly during the morning.

CLINICAL DISCUSSION

DR. B. K. WISEMAN: In some respects this case seems pretty clear-cut. Let us summarize the chief findings: This patient was hospitalized about 10 or 12 years ago for what was thought to be a gallbladder attack in which there was jaundice, fever and colicky pain the right upper quadrant. That is a pretty good description of gallbladder disease and I don't doubt that this had occurred. However, incidental to her hospitalization it was found that she had a very large spleen and a very large liver. Blood counts at that time I think were not available. In any case she got along quite well initially and only later ensued a long period of gradually progressing disability with enlarging spleen, enlarging liver and a continued inability to get about. She went to several hospitals, where a diagnosis of myelosclerosis was suggested.

MYELOID LEUKEMIA?

The most outstanding finding on her present physical examination was a tremendously enlarged liver and spleen, both extending to the brim of the pelvis, with some ascites and some peripheral edema over the legs. The blood study suggested first the characteristic findings of a myeloid leukemia. The white blood count fluctuated between 57,000 and 146,000, the latter count on the day of her demise. The differential count showed the usual findings of a chronic myeloid leukemia. The red blood cells and the platelets were normal. The hemoglobin was disproportionately low.

Several attempts to secure a satisfactory specimen of bone marrow failed to obtain cellular marrow. What were actually found were large clumps of blood platelets with some coils of fibrous tissue and a scattering of myeloid elements, normoblasts and other usual bone marrow cells. This failure to obtain normal bone marrow at many places is a characteristic experience in a case of myelosclerosis. For this reason, Dr. von Haam, I don't think we should hestitate to make such a diagnosis. I don't know of any other condition which would produce such a picture.

The patient did show a peripheral blood picture of chronic myeloid leukemia. She had a tremendously enlarged liver and spleen, but she had very few cells present in the bone marrow taps although many attempts were made. Now in a chronic myelogenous leukemia one always obtains bone marrow specimens very easily and among perhaps several thousand cases of myelogenous leukemia which we have seen at this institution we have never had a failure in getting a bone marrow specimen. Usually we get it on the first attempt. So I think that the only alternative diagnosis, that of chronic myelogenous leukemia, is pretty much out of the picture on the basis of this one finding. The bones of course show changes in this condition and I am relying on Dr. Morton to demonstrate and to discuss the characteristic changes of myelosclerosis.

The other two points of interest in this case refer to her heart and kidney condition.

You will recall that the cardiac consultant

had thought that the patient suffered from a very large right ventricle with probably right ventricular failure based upon a chronic cor pulmonale of some unexplained etiology. He even suggested that she might have an interatrial septal defect. I notice in the records that one examiner described a systolic murmur at the apex associated with a thrill, and if this was a valid observation I would certainly think that the individual suffered from mitral stenosis. The trouble with those notes on the charts is that you can't always believe what you read and that is especially true when a second and perhaps more skilled individual comes along and fails to confirm certain findings. However, there is no question but that the patient did have a large right ventricle compatible with a chronic cor pulmonale.

MITRAL STENOSIS?

Now of all the things I know that commonly produce a large right ventricle with right ventricular failure the most common condition is mitral stenosis. It is a common disease, and it is also common that in advanced mitral stenosis we are not able to hear any diastolic murmur at all. The cardiac examiner must depend upon findings of a diastolic apical murmur before committing himself to the diagnosis of mitral stenosis. So many times that is not true.

There are lots of individuals examined here with findings of mitral stenosis in whom the condition was suspected during the clinical examination, as Dr. von Haam's autopsy experience will bear out. I think that is largely because the existence of a diastolic murmur is overemphasized and that many individuals fail to make a diagnosis when they fail to find a diastolic murmur. I feel that the presence of a chronic cor pulmonale, a large right ventricle which is failing, is an observation which is just as valid, particularly when we read that at least one examiner noticed a systolic apical murmur with a thrill.

The cardiac consultant thought of an interatrial septal defect, a relative tricuspid insufficiency and a failing right ventricle. If we should have a mitral stenosis on top of that we would have a combined lesion of an interatrial defect with mitral stenosis, which is known as Lutembacher's syndrome. I am definitely not satisfied with the explanation that the patient's heart symptoms were due to anemia or some other generalized condition. The patient did not have enough anemia to produce this type of heart pathology. I do definitely think that the patient had some intrinsic heart disease the exact nature of which is not clear. It is my opinion that it could be plain mitral stenosis, which is most common and the most common things usually pay off best in the long run of differential diagnoses. But it could be a combined lesion such as Lutembacher's syndrome and the loud murmur heard at the left fourth interspace could possibly be due to a relative functional regurgitation of the tricuspid valve.

The other point of interest in this case is the diagnosis of her kidney condition. The patient's urine showed a low specific gravity and her phenolsulfonphthalein test was less than 10 per cent in two hours. Her blood urea nitrogen determinations varied between 88 and 115 mg. The patient apparently died in moderate uremia although I don't think that uremia was the cause of death.

Why should the patient suffer from kidney disease? She did not have hypertension. Her urinary studies were of course quite scanty and do not indicate a nephritis or pyelonephritis although pyelonephritis may show very few findings in a casual urine examination. Unfortunately the patient did not live long enough to have a good diagnostic study as far as her urinary system is concerned. She needed some catheterization studies and perhaps a retrograde pyelogram. I am discussing the kidney part because in myelosclerosis with intense ectopic blood cell formation the kidneys sometimes participate in this blood cell formation in addition to the liver and spleen.

In these cases we find large numbers of normoblasts and myeloid cells in the kidney with enlargement of the organ and suppression of the renal function—in other words, the same sequence that we see in leukemic infiltration. Uremia in chronic myeloid leukemia is not a rare observation. Whether it has happened in this patient or not is not possible to state. It is obviously too speculative to attempt to determine why this patient had a poor urinary output with nitrogen retention without having additional urologic data. I simply mention the possibility of ectopic blood cell formation as an interesting thing that sometimes does happen although we have no assurance that this actually has been the case.

Finally, I think that the patient had gallstones. The shadows that were demonstrated on the x-ray plate plus the history of some years ago, her hospital experience, etc., are quite characteristic of gallbladder disease.

In summary therefore, Dr. von Haam, I would like to state that: The patient's primary or main condition was a primary type of myelosclerosis and that this condition was aggravated by an organic heart disease the exact nature of which is not clear but which could very well be plain mitral stenosis leading to cor pulmonale and right ventricular failure. As far as the kidney disease is concerned, I have no very strong conviction on what might be present but I do believe that the patient had an impaired kidney function during her last hospital admis-

sion. Finally, I think the patient suffered from gallstones.

CLINICAL DIAGNOSIS

1. Primary myelofibrosis with extramedullary blood cell formation in liver and spleen.
2. Organic heart disease with cor pulmonale and cardiac decompensation.
3. Renal insufficiency due to organic kidney disease with chronic uremia.
4. Gallstones.

GENERAL DISCUSSION

DR. E. VON HAAM: Dr. Morton, do you have anything to add to this diagnosis?

DR. J. L. MORTON: The x-ray pictures of the skeleton suggest dense bone with the ground substance between the bone plates infiltrated with calcium or some similar material. This is definitely marble bone. We differentiate between the infantile and adult types of marble bone disease and usually the adult type has bigger bones and does not show the ordinary tubulation. The patient's picture would suggest that her sclerosis was more of a later acquisition. Without knowing the history of the patient one would probably think of extensive tumor metastasis. With the history, however, particularly with a time factor of 10 years, we agree that myelosclerosis with marble bone disease is the most likely diagnosis. The heart silhouette was 50 per cent over that expected for the patient's height and weight. We suggest myocardial changes with fatty degeneration due to her longstanding anemia, possibly with coronary sclerosis thrown in. The calcific shadows in the abdomen may be gallstones or kidney stones. The exact differential diagnosis is not possible from the plates.

MEDICAL STUDENT: How can you explain the high percentage of reticulocytes in the blood stream?

DR. WISEMAN: This always occurs whenever you get ectopic blood cell formation. Apparently the barriers in the spleen and other organs are not as efficient as in the bone marrow and do not keep the reticulocytes from washing out in the blood stream. The bone marrow has a very finely adjusted mechanism whereby it lets reticulocytes out only under certain conditions. These regulating influences are not present in the liver and spleen and therefore a reticulocytosis in a proven case of ectopic blood cell formation has not the same significance as in individuals without ectopic blood cell formation.

DR. G. J. HAMWI: I would like to have Dr. Wiseman discuss primary and secondary myelosclerosis.

DR. WISEMAN: I think the concept of secondary myelofibrosis is self-explanatory. It can be seen in Paget's disease, in osteopetrosis, in metastatic tumors or in cases of injury to the bone marrow by a chemical or physical agent.

Primary myelosclerosis is more difficult to understand. It consists in the replacement of the normal bone marrow elements by a proliferation of the reticulum elements and collagenous tissue and sometimes is associated with fatty infiltration or even gelatinous degeneration of the marrow. The end-stage is uniformly that of a fibrous displacement of the bone marrow contents with complete disappearance of the normal cellular elements. Coincident with that ectopic blood cell formation takes place; blood cells form in the liver, spleen, lymph nodes and in other organs.

It is the feeling among hematologists and pathologists that myelofibrosis of the primary type is a disease beyond that of replacement of marrow by fibrous tissue. It is an entity by itself. It does not run the course of secondary myelofibrosis. There is some suspicion that perhaps in the last analysis this is a disease of the reticulo-endothelial system in which reticulo-endothelial cells convert into fibroblasts. Primary myelofibrosis has some characteristic pathology which seems to make one feel that it is a specific disease and not secondary to some other disorder.

PATHOLOGIC DIAGNOSIS

1. Primary myelofibrosis.
2. Agnogenic myeloid metaplasia involving liver, spleen and lymph nodes.
3. Chronic rheumatic heart disease with:
   (a) Stenosis of the mitral ostium.
   (b) Right ventricular hypertrophy.
   (c) Mild myocardial fibrosis.
4. Chronic cholecystitis and cholelithiasis.
5. Pyelonephritis with renal calculi.
6. Multiple uterine fibroids.
7. Ascites.

PATHOLOGIC DISCUSSION

DR. VON HAAM: The body of the patient appeared emaciated, weighing an estimated 100 pounds. The lymph nodes in both axillary and inguinal regions were slightly enlarged. The abdominal cavity contained approximately 1000 cc. of a clear yellow fluid.

The heart was enlarged and had a transverse diameter of 15.5 cm. The right ventricle appeared thickened and the papillary muscles of the right heart appeared thicker than usual. The mitral leaflets contained numerous areas of calcification on the inferior surface of the valve leaflets and along the free margin. The circumference of the tricuspid valve was 13.5 cm.

The spleen was tremendously enlarged, weighing 2580 grams. The spleen was firm and contained numerous gray-yellow infarcts. The splenic capsule showed the pearly white thicken-

ing of a sugar-coated spleen. The liver was also enlarged and weighed 5060 grams. The cut surface revealed a mottled grayish-pink tissue. The gallbladder contained one single egg-shaped calculus measuring 1.5 cm. in length. The gastrointestinal tract appeared normal.

The kidneys were unequal in size and weighed 160 and 200 grams. The pelves and calyces of the kidneys were dilated up to twice the normal caliber and contained numerous friable brownish-gray calculi. The uterus was enlarged and contained numerous tumors typical of uterine fibroids. The lymph nodes of the mesentery and in the retroperitoneal space appeared slightly enlarged, gray and firm. Section of the skeletal system showed diffuse fibrosis of the marrow cavity. The cut surfaces of various bones had a homogeneous pale-gray appearance. The ribs contained only a thin serosanguineous fluid. The bone marrow in the distal one-third of the femur appeared moist and dark red.

MICROSCOPIC EXAMINATION

Microscopic examination of the heart showed shortening and thickening of the chordae tendineae and a definite calcification of the mitral valve. In the myocardium areas of perivascular fibrosis could be observed which suggested together with the changes in the endocardium that the patient suffered from old rheumatic heart disease. Sections through the lungs showed numerous megakaryocytes in the capillaries with many other myeloid cells. The question as to whether those cells originated in the lung or if they were retained in the lung but originated in other organs must remain unsolved.

THE SPLEEN

Section of the spleen showed the classical picture of myeloid metaplasia. The sinusoids were universally distended and filled with cells of the erythropoietic, myeloid and megakaryocytic series. The same cells were present in the distended sinusoids of the liver. We were particularly impressed by the tremendous number of megakaryocytes in the liver and spleen. Sections through the kidneys showed evidence of rather severe inflammatory changes of the type of pyelonephritis. Small abscesses filled with polymorphonuclear leukocytes were found in the interstitial tissue together with changes in the glomeruli and blood vessels. Stains for amyloid showed a beginning amyloidosis in some glomeruli. The kidney picture was definitely that of an acute inflammation and not of myeloid metaplasia as suggested by Dr. Wiseman.

THE LYMPH NODES

Sections through the lymph nodes showed again the picture of myeloid metaplasia with numerous megakaryocytes in the parenchyma. Sections through various portions of the bone marrow showed a condition interpreted by us as primary bone marrow fibrosis. I do not think that the histological examination justified the diagnosis of marble-bone disease. The bone trabeculae were not remarkably thickened and the intertrabecular spaces appeared quite large and were filled with fibrous tissue. In fact, in some of the bone sections the trabecular pattern appeared rather pronounced and some of the trabeculae appeared thinner than usual. In some of the sections of the ribs small foci of active bone marrow could be found. Sections through the endocrine glands and the other organs revealed no evidence of pathology.

In summarizing our pathological examinations I may state that the patient showed the picture of primary myelofibrosis with agnogenic myeloid metaplasia of liver, spleen and lymph nodes. In addition there was evidence of chronic rheumatic heart disease with moderately advanced mitral stenosis and right ventricular hypertrophy. Finally, there was present severe bilateral pyelonephritis with nephrolithiasis and severe damage to the kidney parenchyma. There was also evidence of chronic cholecystitis with cholelithiasis. You can see that our pathological diagnosis represents basically a confirmation of Dr. Wiseman's clinical diagnosis. This case serves to show how a carefully performed examination can produce a good diagnosis in a short time. I think that the myelofibrosis of this patient is of the primary or idiopathic type. I do not think that the bone trabeculae are thick enough to warrant the diagnosis of marble-bone disease in spite of the x-ray picture.

The one thing which the clinical discussant mentioned but missed in its importance as far as the patient's state of health was concerned was the advanced kidney disease. It fully explains the few laboratory data obtained and definitely proves that the patient was in renal failure with beginning uremia.

GENERAL DISCUSSION

DR. HAMWI: A question frequently asked at a clinicopathological conference is, "What did the patient die of?"

DR. WISEMAN: I never know what anybody dies of. As a matter of fact I often don't know why anybody is alive to begin with.

DR. S. SASLAW: There seem to have been lots of things wrong with the patient. Of course you can say she died of heart failure, but what do you mean when you say, "She died of heart failure?"

DR. VON HAAM: I think I can answer the question of why the patient died. I believe more than one factor was involved in her death. Her primary disease, that of idiopathic myeloid fibrosis, is probably the least important factor in her death. I think Dr. Wiseman will agree with me in this. I believe the patient was in severe kidney failure and also developed right heart

failure. A combination of the two conditions was responsible for the death of the patient. You remember that the patient was comparatively well when she came into the hospital and died rather suddenly. This type of death is typical of right ventricular failure and we are right to assume that the uremic condition of the patient was an important factor in bringing about this right ventricular failure.

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Incidence of Trichinae in Swine

Of the many mammalian hosts of *Trichinella spiralis*, only the domestic hog is of significant importance from the standpoint of human health. There is reason to believe that at one time our domestic swine were infected with trichinae to a much greater extent, and to a significantly greater degree than at the present time.

In the 1930's nearly 1 per cent of our farm raised hogs, and about 10 per cent of the garbage-fed hogs in the Atlantic Seaboard states, harbored trichinae. At least two-thirds of the infected farm-raised hogs contained these parasites in numbers so small that they would undoubtedly have escaped detection by routine microscopic inspection, whereas the parasites in the infected garbage-fed hogs were numerous enough to be detected in about two-thirds of the cases.

In a study recently completed, the incidence of trichinae in over 3000 hogs originating in several Corn-Belt states was only 0.6 per cent, when the examinations were made by digesting the pillars of the diaphragm in acidified pepsin. Trichinae were not found, however, in any of these infected diaphragms when examined routinely in press preparations, showing, therefore, that they were very lightly infected.

In parallel studies, a series of about 1500 samples from garbage-fed hogs on the Eastern Seaboard showed an incidence of 11.5 per cent, determined by digestion, and nearly 5 per cent when examined routinely in press preparations.

These data re-emphasize the role of garbage feeding in the transmission of trichinae to pigs, and through their pork to human beings who eat this meat raw, inadequately cooked, or imperfectly cured.—BENJAMIN SCHWARTZ, M. D., chief, zoology division, Bureau of Animal Industry, Washington, D. C.

Abstract of paper presented at 1952 National Conference on Trichinosis, Auditorium, American Medical Association, December 15, 1952.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Epididymis—Literally meaning "upon the twins," this term is composed of the Greek words "epi," or upon, and "didymos" meaning double or twin. For obvious reasons the Greeks called the testicles by the name of "didymos," or the twins. Galen in the second century applied the term "epididymis" to the outer membrane of the testis. However, modern usage applies the term to that portion of the seminal duct lying posterior to the testis.

Ecology—The science of the study of the relationship between organisms and their environment. This term is derived from the Greek words "oikos," or house, plus "logos," or discourse. The term was applied in the sense that the environment is the house in which all organisms live.

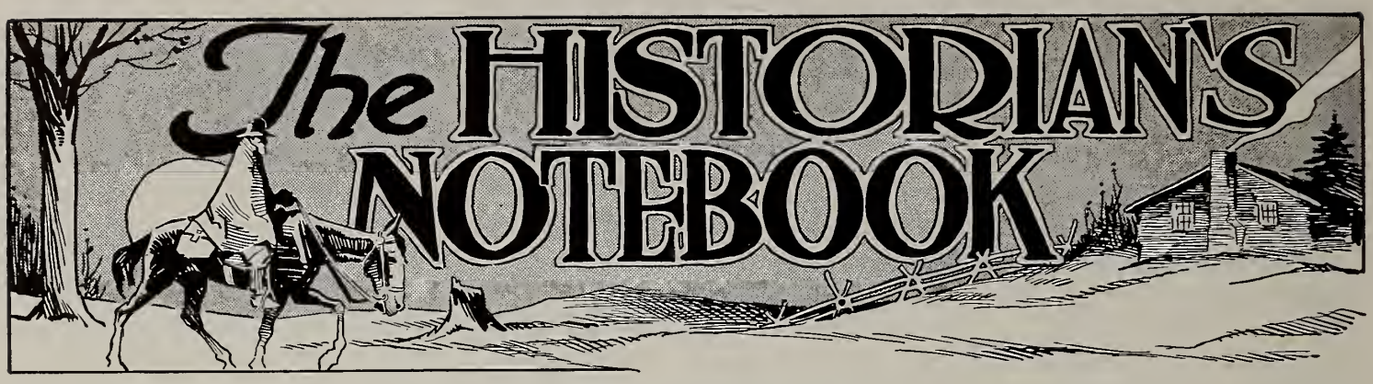
Haustrum—Haustra—Coming from the Latin word "haurire" meaning to draw, the New Latin term "haustrum" designated a pump and originally it referred to a machine for drawing up water which consisted of a series or chain of buckets. Because the colon has a series of pouches or sacculations the early anatomists saw in this structure a fancied resemblance to a series of buckets and thus descriptively named them "haustra." Thus a single pouch was called a haustrum and the colon was said to be haustrated.

Silly—This term evolved from the Anglo-Saxon word "saelig" and the German word "selig," both meaning blessed. The term came to be used in the sense that the "silly" or foolish were touched or blessed by God. It is also related that following the Norman Conquest the Normans had nothing to do but to hunt and play and thus they were blessed or saelig. Later they were called "seely" and this by extension came to mean foolish.

Sodomy—This term is of Biblical origin and denotes copulation between males or sexual connection by anus. This unnatural crime is so called because it was attributed to the inhabitants of Sodom, a former city of Asia. As a punishment for these vices, we read in *Genesis XIX: 24-25* "Then the Lord rained upon Sodom and Gomorrah brimstone and fire."

Solar Plexus—This is the common or lay name for the celiac plexus which is a large nerve center situated in the abdominal cavity. The force of a blow or a punch over the "solar plexus" produces unconsciousness or a "blackout," hence you literally hit the sun and black it out. The term is derived from the Latin word "solaris" meaning of, or belonging to, the sun.

—HARRY WAIN, M. D., Mansfield, Ohio.



Memorial to Richard Allison, M. D.

CINCINNATI formally acquired a new historical monument on April 8—a plaque at the northeast corner of Third and Lawrence Streets, honoring Richard Allison, M. D., first practicing physician in the Cincinnati area.

At dedicatory ceremonies, Drs. Cecil Striker and David A. Tucker, Jr., represented the Academy of Medicine of Cincinnati, which donated the bronze tablet placed in memory of Dr. Allison. Virginius C. Hall represented the Ohio Historical and Philosophical Society, and Charles Schneider, chairman of the City Recreation Commission, acknowledged the placement of the monument at the corner of a playground area.

The site is near where Dr. Allison's residence, "Peach Grove," was located.

The Inscription on the plaque reads as follows:

DOCTOR RICHARD ALLISON
1757-1816

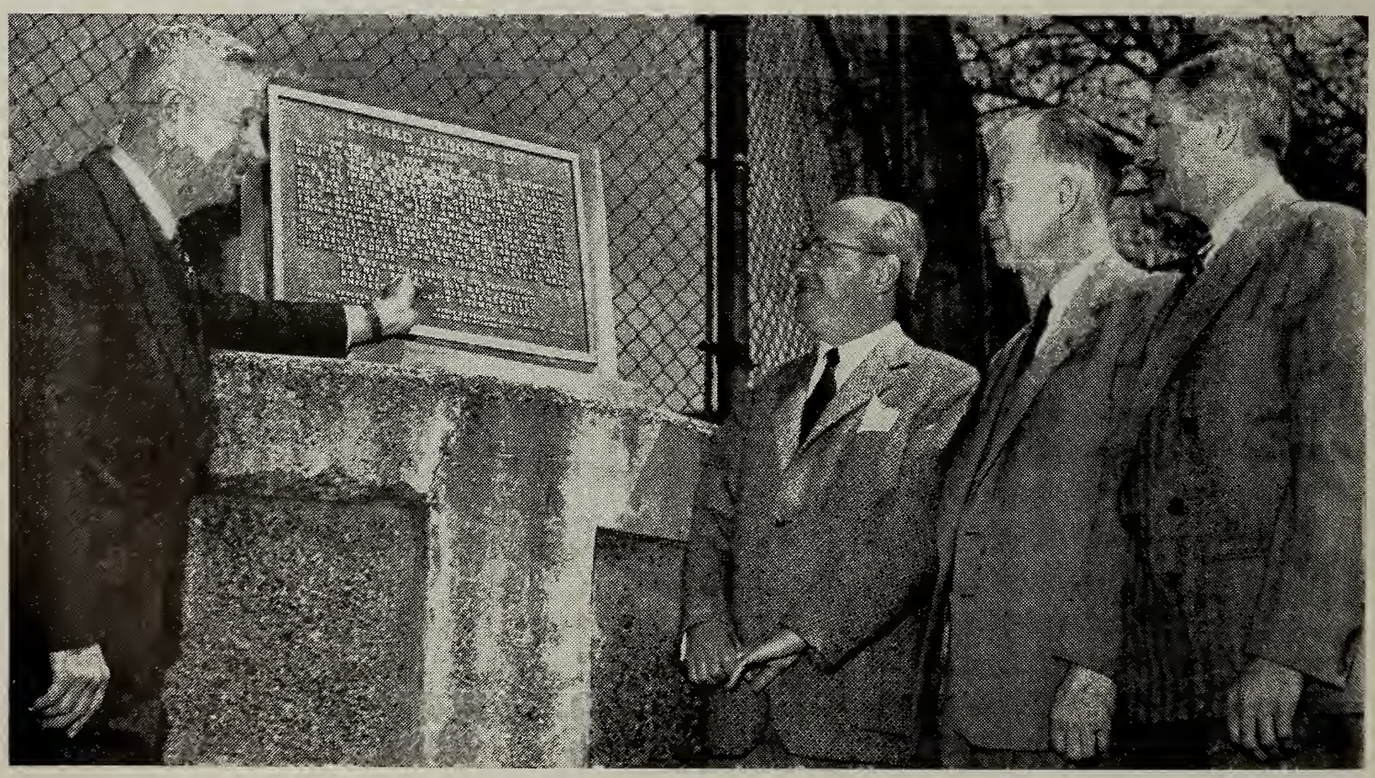
On this site, just east of Fort Washington, Doctor Richard Allison, Surgeon to the Legion, built his "Peach Grove" house about the year 1795.

He was a veteran of the American Revolution and the Indian Wars, having risen from surgeon's mate to ranking medical officer and Surgeon to the Legion of the United States. In 1789 he came to the West and was stationed at Fort Washington, taking an active part in the campaigns against the Indians under Generals Josiah Harmar, Arthur St. Clair and Anthony Wayne.

After retirement from the army in 1796, he continued the practice of medicine in Cincinnati and in Clermont County. His quiet courtesy endeared him to people in every rank of frontier life.

"He was an ornament to his profession . . In his bounty, distress found relief and in his generosity, unfortunate merit found refuge."

Erected in honor of the first physician and surgeon in this vicinity by
The Academy of Medicine of Cincinnati



Key persons in the dedication of the Allison memorial plaque are shown above, left to right: Mr. Hall, Dr. Striker, Dr. Tucker and Mr. Schneider.

Porterfield Named . . .

Director of Health Accepts Post as Head of New Department of Mental Hygiene and Correction; Dwork To Head Health Department Temporarily

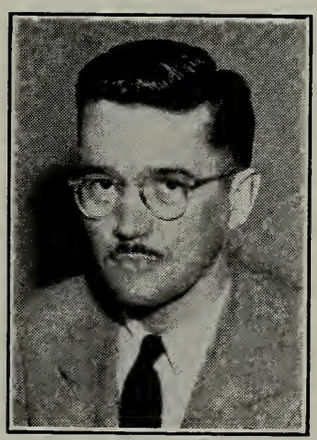
APPOINTMENT of Dr. John D. Porterfield, for seven years director of the Ohio Department of Health, as director of the newly created Ohio Department of Mental Hygiene and Correction climaxed a reorganization program effective on July 1.

Shortly after the announcement of his appointment by Governor Lausche, Dr. Porterfield outlined for *The Journal* proposals which presage a new approach in the state's mental health program.

Emphasis on prevention, which has long been the basis of approach in the public health field, will become the basis for the state's new program in mental hygiene under Dr. Porterfield's direction.

Insofar as possible, prevention also will be a major goal in the field of social maladjustment as related to the state's penal and correctional program, he announced.

Dr. Porterfield's appointment was one of the developments in a reorganization program affecting two major state departments and creating a new department. The Ohio General Assembly at its last session created the State Department of Mental Hygiene and Correction, effective July 1, 1954. This Department will comprise the Divisions of Mental Hygiene; Correction; Juvenile Research, Classification and Training; and the Division of Business Administration—all formerly parts of the State Department of Public Welfare.



J. D. PORTERFIELD, M. D.

The State Department of Public Welfare now will consist of the Divisions of Aid for the Aged, Social Administration, and a small Division of Business Administration.

ADMINISTRATIVE DEVELOPMENTS

Administrative developments involved in this reorganization included:

1. Appointment of Dr. Porterfield.

2. Continuation of Judge Henry J. Robison as director of the State Department of Public Welfare in its new status.

3. Appointment of Dr. Ralph E. Dwork, for several years chief of the Divisions of Tuberculosis and Chronic Diseases of the Department of Health, as assistant director of the Department of Health, by virtue of which position he will be in charge of the Department of Health until a permanent director is named by the Governor from a list of six nominations to be presented by the Ohio Public Health Council.

The new director of the Department of Mental Hygiene and Correction is authorized to appoint chiefs of the Divisions of Mental Hygiene; Correction; and Juvenile Research, Classification and Training.

The chief of the Division of Mental Hygiene will hold the title of Commissioner of Mental Hygiene. Dr. Lowell O. Dillon is the incumbent commissioner.

Present chief of the Division of Correction is Maury C. Koblentz. Chief of the Division of Juvenile Research, Classification and Training is John R. Ferguson.

SOME PRINCIPLES OF POLICY

As this issue of *The Journal* went to press, Dr. Porterfield was still in process of formulating policy in regard to his new duties. He did, however, offer some principles on which his policies would be based.

He said that he believed the amount of money spent on care of mental patients was out of proportion to the small amount spent for preventing mental illness. He expressed the conviction that those who are engaged in mental health work must devote as much time and attention on how to keep people out of mental institutions as on how to get them out.

He sees a need for a tremendously expanded educational program for mental health, plus an intensive development of community activity in focusing attention on the mental health problem.

He feels that there should be coördination between local health departments and mental hygiene work as a requisite to effective local programs. He is opposed to the idea that the public health clinic should be on one side of the street and the mental health clinic on the other side.

And he is very much in favor of the development on a statewide basis of out-patient mental hygiene clinics where steps can be taken to preserve sound mental health long before the need for institutional treatment. This, he feels, can lead to eventual financial savings for the state at the same time that it is preserving a higher level of mental health.

Dr. Porterfield sees as his first responsibility a complete review of present operating procedures

and programs at the existing mental institutions, juvenile centers, reformatories and prisons. Effective treatment and rehabilitation can be considered the principal aim of all of these, he said.

JUVENILE FIELD

In the juvenile field, he stressed the importance of preventive measures as well as rehabilitation when he said: "We will continue our efforts to rehabilitate and correct delinquents and at the same time stress and emphasize preventive measures."

He let it be known that his thinking falls somewhere between the two current poles of thought about the delinquent in an institution. He hopes to find "some middle ground" of sympathetic understanding treatment "which at the same time considers the rights of the public."

He would like to see more parent education programs, more youth centers where teen-aged boys and girls can be with their own kind. And he would stimulate the development of guidance centers to help both parents and children with mental and emotional problems.

At all institutions he would seek improved methods of operation to effect economies and efficiencies where possible with the desire to make the best use of available operating funds.

Classification of patients at mental hospitals would be intensified toward providing greater concentration on those most likely to benefit from the care available.

Senile patients who need plain domiciliary care would be happier elsewhere than in mental hospitals, in the opinion of Dr. Porterfield. Other provision for their care would release many beds for those who truly need to be in mental hospitals and at the same time would greatly reduce the cost of caring for senility cases.

Dr. Porterfield said he realized that a continued building program would have to be considered, but the first step would be to make best use of what we have, and then to consider the need for improvement, replacement and extension of facilities. Along with this everything should be done to improve morale and provide satisfactory compensation to keep and acquire adequate staffs at the state's institutions.

The law which created the new department made no attempt to solve the financial needs in mental hygiene work or in the work of other divisions, Dr. Porterfield observed. He said he believes that the Legislature meeting in January will expect him to make a full report on these needs, and that he will be prepared to make such a report on the overall picture.

DR. PORTERFIELD'S BACKGROUND

Dr. Porterfield has had previous experience in mental health work, which also included close liaison with prision administration.

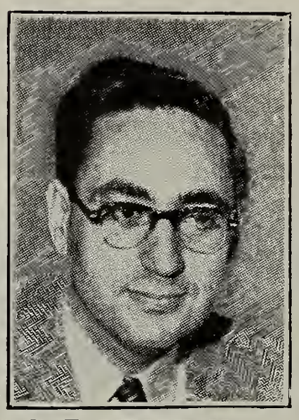
A graduate of Rush Medical College, University of Chicago, 1938, and the fifth consecutive generation of his family in the medical profession, he took his internship in the U. S. Marine Hospital, San Francisco, then entered the U. S. Public Health Service where he attained the rank of senior surgeon.

As part of his Public Health Service work, he served at two narcotic hospitals, at Lexington and Fort Worth. In this work with narcotics addicts he had close acquaintance with the Federal Bureau of Prisons. During his internship he also once served as a substitute medical officer at Alcatraz.

Dr. Porterfield attended the School of Hygiene and Public Health, Johns Hopkins University, and received the degree of Master of Public Health in 1944. He was certified by the American Board of Preventive Medicine and Public Health in 1949. He had been director of the Ohio Department of Health since 1947. He is presently vice-president of the Association of State and Territorial Health Officers and is chairman of the Editorial Board of the American Journal of Public Health.

DR. DWORK

Dr. Dwork, the new assistant director and acting director of the Ohio Department of Health, has been with the Department since 1950. He is an assistant professor of preventive medicine at Ohio State University.



R. E. DWORK, M. D.

Dr. Dwork came to Ohio from New York City where he was health officer in charge of the Tremont and Fordham-Riverdale Districts.

Dr. Dwork studied medicine at the University of Edinburgh and at Anderson College of Medicine, Glasgow, Scotland, where he received his L.R.C.P.S. degree in 1946. Internship was in Syndenham Hospital, New York City. He did residency work in chronic diseases with the National Jewish Hospital, Denver, for three years, and later received the degree of Master of Public Health from the Columbia University School of Public Health.

Course on Chest Diseases

The seventh annual Postgraduate Course on Diseases of the Chest will be held at the Hotel New Yorker, New York City, November 8-12. Information may be obtained from the American College of Chest Physicians, 112 East Chestnut St., Chicago 11, which is sponsoring the course in cooperation with various state chapters.

Proceedings of The Council . . .

Important Items of Business Transacted at Meeting on May 23 in Headquarters Office; Committee Reports Received and Acted Upon

A REGULAR meeting of The Council of the Ohio State Medical Association was held at the Columbus office on Sunday, May 23, 1954. All members of The Council, except Dr. E. H. Artman, Chillicothe, were in attendance. Others in attendance were: Dr. Wm. M. Skipp, Youngstown, an A. M. A. delegate; Mr. Wayne E. Stichter, Toledo, legal counsel; Secretaries Nelson, Saville and Page and Mr. R. Gordon Moore, assistant managing editor of *The Journal.*

Following remarks by President Prugh, the minutes of meetings of The Council held on April 11 and 15, 1954, were approved, on motion duly made, seconded and carried.

MEMBERSHIP STATISTICS

Membership statistics were presented by the Executive Secretary as follows:

Ohio State Medical Association membership as of May 21, 1954—7,883, compared to a total membership of 8,068 as of December 31, 1953.

American Medical Association membership as of May 21, 1954—6,832, compared to a total of 6,941 who were members as of December 31, 1953.

Past-presidents' buttons for the past-presidents who were not in attendance at the recent Annual Meeting, were given to the respective members of The Council for presentation to such past-presidents at some meeting of their county societies or individually.

ANNUAL MEETING

There was a thorough discussion of the recent Annual Meeting in Columbus.

Members of The Council expressed a general satisfaction with the program and schedule. A number of suggestions were offered for consideration by the Committee on Scientific Work when it meets to make arrangements for the 1955 Annual Meeting.

The question of time and place for the 1957 Annual Meeting was discussed. The Council expressed itself as believing that the 1957 meeting should be held in Columbus, if the new public auditorium in Columbus will be large enough to accommodate most of the meeting. The action of the Executive Secretary in securing tentative dates in Columbus and in Cincinnati for the 1957 Annual Meeting was approved—the final decision to be made later by The Council.

WILSON CASE

The Council then considered the appeal of Dr. Harold J. Wilson, Columbus, from the order of expulsion entered by the Columbus Academy of Medicine on April 13, 1953. Ten members of The Council participated. Doctors Atkinson, Hopkins and Pease, newly elected members of The Council, and Dr. R. L. Meiling did not participate. Dr. Meiling had disqualified himself on his own request at the time of the hearing on January 16, 1954, because he had participated in the original action of expulsion by the Columbus Academy of Medicine. Dr. Artman was not in attendance.

The ten Councilors participating, by a unanimous vote, returned a decision and order affirming and sustaining the order of expulsion of Dr. Harold J. Wilson by the Columbus Academy of Medicine. The Executive Secretary was ordered to notify Dr. Wilson and his attorneys and the Columbus Academy of Medicine and its attorneys of The Council's action. The decision and order adopted was as follows:

BEFORE THE COUNCIL OF THE OHIO STATE MEDICAL ASSOCIATION

In re: Expulsion of Dr. Harold J. Wilson from membership in the Columbus Academy of Medicine	:	Decision and Order on the Appeal of Dr. Harold J. Wilson, Columbus, Ohio

May 23, 1954

The Council of the Ohio State Medical Association has given careful consideration to the appeal filed by Dr. Harold J. Wilson from the order of the Columbus Academy of Medicine, dated April 13, 1953, expelling Dr. Wilson from membership in that Academy, and to the briefs and oral arguments of counsel for each party, presented to The Council of the Ohio State Medical Association on Saturday, January 16, 1954. Upon a careful examination and consideration of the proceedings before the Columbus Academy of Medicine on the charges filed against Dr. Wilson, including the transcript of the testimony offered at the trial on such charges and the exhibits received in evidence at such trial. The Council of the Ohio State Medical Association finds:

1. The proceedings before the Council of the Columbus Academy of Medicine and before the membership of the Academy were each in accordance with the Constitution and By-Laws of the Academy and the Constitution and By-Laws of the Ohio State Medical Association.

2. Dr. Wilson was afforded full and ample opportunity by the Council of the Academy to be heard in the defense of the charges filed against him. He and his two attorneys were in attendance at the commencement of the trial

before the Council of the Academy and offered in evidence certain documents and certain stipulations of counsel. At no time were Dr. Wilson or his attorneys deprived of the right or opportunity to cross-examine the witnesses offered by the Public Relations Committee of the Academy, or to produce and examine witnesses on Dr. Wilson's own behalf, or to otherwise participate fully in the trial. Instead of so participating, Dr. Wilson and his attorneys withdrew from the hearing before the Council of the Academy and made no further defense other than the offering of the exhibits and stipulations above-mentioned. The record of the proceedings fails to show any abuse of discretion, or arbitrary or unreasonable decision, on the part of the Council of the Academy, or any erroneous ruling prejudicial to the rights of Dr. Wilson. On the contrary, the record clearly shows that Dr. Wilson was given a fair and impartial trial before the Council of the Academy and the Academy membership.

3. The charges that Dr. Wilson was guilty of misconduct prejudicial to the reputation and welfare of the Columbus Academy of Medicine, of unprofessional conduct, and of conduct in violation of the Principles of Medical Ethics of the American Medical Association are fully sustained by the 262 pages of sworn testimony of 28 witnesses who testified orally at the trial and by the approximately 90 exhibits that were received in evidence.

It is therefore ordered and decreed that the decision and order of the Columbus Academy of Medicine, entered April 13, 1953, expelling Dr. Harold J. Wilson from membership in the Columbus Academy of Medicine be and the same hereby is affirmed and sustained.

LEGISLATIVE ACTIVITIES

The Council then considered a report from the Committee on Legislation, based on a meeting of that committee held on Sunday, May 9, 1954. The Council approved a recommendation of the committee that the Association follow this year a pre-election educational program similar to the one used in past years, and instructed the Columbus office to proceed immediately with arrangements for securing information regarding candidates and for the holding of district legislative meetings in September.

COMMITTEE ON CANCER REPORT

A report of the Committee on Cancer was considered by The Council. The Committee on Cancer had met on April 12 during the Annual Meeting in Columbus. On motion made, seconded and carried, The Council approved a recommendation of the committee that a uniform system of voluntary cancer registries be established in Ohio and that the Ohio Department of Health, Ohio Division of the American Cancer Society and its local units, the Ohio Hospital Association and the Ohio State Dental Society be officially requested by the Ohio State Medical Association to work with the Association, through the Committee on Cancer, in developing details and policies for such a program.

HOSPITAL PROBLEMS

Dr. Woodhouse submitted a report on behalf of the Committee on Hospital Relations. He stated that the committee had held several meetings, the last as recently as Saturday evening, May 22. Dr. Woodhouse pointed out that all County Medical Societies had been requested to forward information, comments and criticisms regarding surveys made by the Joint Commission on Hospital Accreditation and that replies had been received from 32 counties.

Dr. Woodhouse stated that the replies from these counties would seem to indicate that certain procedures and regulations of the hospital accreditation program should be modified to meet the situation of certain hospitals, primarily the smaller hospitals. He stated, however, that the committee is not ready at this time to make definite recommendations for submission to the American Medical Association or to the Commission direct.

Dr. Woodhouse said the committee had been advised that one of the committees of the National Commission is studying the problems of the small hospitals and that another committee of the Commission is studying the problem of consultations. Dr. Woodhouse said that these committees probably would submit reports to the Commission by next July or next September. His committee, Dr. Woodhouse said, believes that it would be wise to withhold the making of recommendations until the committee has had a chance to review recommendations which may be made by the two committees of the Joint Commission.

Dr. Woodhouse said also that his committee felt that a more careful check should be made with respect to some of the complaints received by the committee. On behalf of the committee, he then submitted a recommendation that The Council request the Joint Commission to make available to the Committee on Hospital Relations of the Ohio State Medical Association the point scores of hospitals in Ohio which have been refused accreditation and the point scores of hospitals in Ohio which have been given provisional accreditation. Dr. Woodhouse said that the committee believes it would have definite and valuable information for study if the Commission would make these data available. Also, he pointed out that the committee would be in a position to discuss deficiencies alleged to exist in certain hospitals with the staff of such hospitals and might be able to suggest ways and means for the correc-

tion of such deficiencies, thus enabling these hospitals to secure accreditation.

Dr. Woodhouse said the committee would continue with its study of these problems and would endeavor to have a final report with recommendations in the hands of The Council by the time of the September meetings of The Council.

On **motion** made, seconded and **carried**, the report and recommendations of the Committee on Hospital Relations were approved.

PHYSICIANS-SCHOOLS CONFERENCE

Mr. Page submitted a complete report on the Conference on Physicians and Schools held recently at Lake Hope. This conference was sponsored jointly by the State Department of Health, State Department of Education, Ohio Education Association, Ohio State Medical Association and several voluntary health associations. Mr. Page reported that all in attendance considered the conference of supreme importance and one of the most outstanding meetings of this kind ever held in the state. He said those in attendance felt that this should become an annual affair. He reported that 25 physicians who were either members of the Committee on School Health of the Ohio State Medical Association or representatives of County Medical Societies had attended the conference on invitation, and that all had taken an active and prominent part in the proceedings. Mr. Page said that the Committee on School Health had secured many valuable suggestions as the result of the conference and that in all probability the net results of the conference would be the improvement of state-wide and local school health programs in Ohio.

By official action, The Council congratulated Mr. Page on his fine work in helping to arrange the conference and for his participation in it. By the same motion, The Council authorized the Executive Secretary to send a letter to all physicians who participated, thanking them for their interest and cooperation.

MISCELLANEOUS BUSINESS

A communication from the American Medical Association, suggesting the formation of a committee on alcoholism was referred to the Committee on Chronic Illness, with a suggestion that this committee include the question of alcoholism on its program of activity.

The question of the annual subscription price for *The Ohio State Medical Journal* was discussed. On **motion** made, seconded and **carried**, The Council authorized an increase in the annual subscription rate for *The Journal* from $3.00 to $5.00 and an increase in the cost of single copies from 30 cents to 50 cents, such increases to become effective immediately, except in the case of subscriptions now in force, but to apply to subscription renewals.

Following reports by members of The Council on activities in their districts, The Council adjourned to meet at the call of the President or at the Granville Inn, Granville, Ohio, on September 18-19, 1954.

Attest: CHARLES S. NELSON,
Executive Secretary.

Follow-Up Slated for Youngsters In Polio Field Tests

The series of three inoculations of poliomyelitis vaccine given to volunteer school children in Montgomery and Richland Counties was completed early in June and no adverse reactions had been reported, according to Dr. Frederick H. Wentworth, chief of the Division of Communicable Diseases of the Ohio Department of Health.

A total of 16,772 children in the first, second and third grades, consent of whose parents had been obtained, took part in the inoculation field trials—half receiving the vaccine and the other half a placebo solution. Similar tests were given throughout the nation under sponsorship of the National Foundation for Infantile Paralysis, to attempt to evaluate on a large scale the vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh.

A careful follow-up of children who participated in the inoculations, including blood tests on certain children, is being made in the two counties. Evaluation of the trials will be made at the Evaluation Center, University of Michigan, under direction of Dr. Thomas Francis, some time after the wane of the polio season.

The field trials had the backing of the Ohio State Medical Association and of the two Medical Societies of the counties involved. Approximately 300 physicians aided in the tests.

Ohio Team Receives Industrial Medicine Authorship Award

The Industrial Medical Association's Citation for Merit in Authorship award for 1953-1954 went to Dr. Joseph M. DeNardi, Lorain, and Drs. H. S. Van Ordstrand, George H. Curtis and John Zielinski, Cleveland, for their paper entitled, "Berylliosis, Summary and Survey of All Clinical Types Observed in a Twelve-Year Period."

The paper appeared in the *A. M. A. Archives of Industrial Hygiene and Occupational Medicine*, July 1953. The award was made at the Industrial Medical Association annual banquet in Chicago on April 28.

Orientation in Rural Practice . . .

Third Series of Discussions Presented to Senior Medical Students at Ohio State by Association in Cooperation with College Groups

A DINNER MEETING held at the Student Union of the Ohio State University May 26 marked the completion of the third year of a special project to interest more medical graduates in the general practice of medicine with emphasis on rural areas and small cities.

Sponsored by the Committee on Rural Health of the Ohio State Medical Association with the cooperation of the Ohio State University College of Medicine and the Senior Class Cabinet, the project involves a series of five lectures geared to acquaint senior students and their wives with advantages and disadvantages of locating in rural areas and practical information on medical, business, and social aspects involved.

This year a sixth lecture, "A General Practitioner Looks at Medical Ethics," was added to the course. It was presented May 19 by Dr. George A. Woodhouse, Pleasant Hill, Second District Councilor for the Ohio State Medical Association, and a member of the Judicial Council of the American Medical Association.

Other speakers for this year's series were: Dr. Edmond K. Yantes, Wilmington, chairman, Committee on Rural Health, Ohio State Medical Association, and Dr. V. R. Frederick, Urbana, a member of the Committee.

Also participating in this year's series were Dr. Robert E. Reiheld, Orrville, and Dr. Richard R. Buchanan of Wilmington.

Dr. Merrill D. Prugh, Dayton, president of the Ohio State Medical Association, welcomed the guests of the Association at the dinner meeting. In addition to the students and their wives, those present were: Dr. John A. Prior, assistant dean, College of Medicine, Mrs. Margaret Colburn, assistant to the dean; Mrs. Dorothy Smith, assistant to Dr. Prior, Dr. and Mrs. Yantes, Drs. Richard and Emily Buchanan, and Dr. and Mrs. Reiheld. Also present were Messrs. Charles S. Nelson, George H. Saville, and Hart F. Page of the Ohio State Medical Association headquarters staff.

Following the dinner, the wives met with Mrs. Yantes, Mrs. Reiheld, and Dr. Emily Buchanan for a discussion of the life of a doctor's wife, and the seniors heard the closing lecture on "Types of Practice Encountered," by Dr. Yantes.

SUBJECTS COVERED

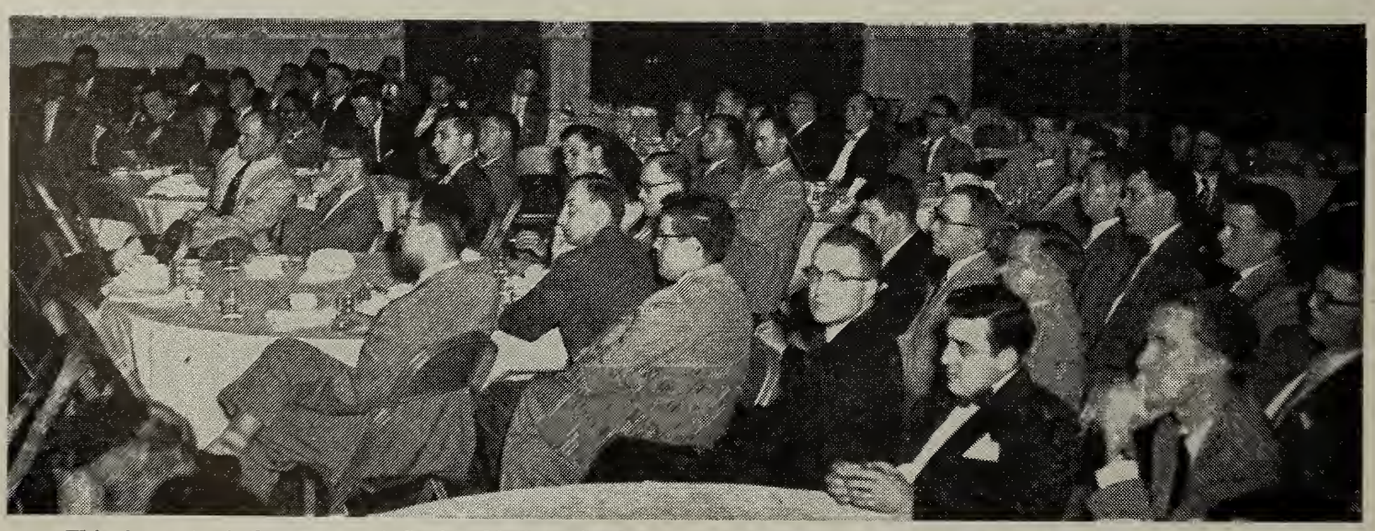
Following is a gist of subjects covered in previous lectures:

"Selecting a Place To Practice"—Needs of the community for a doctor or an additional doctor; community resources for the support of a doctor, its stability, etc.; professional problems, such as attitude of other doctors in area, cooperation of community groups, accessibility to outlying sections, etc.; personal and family problems, such as attitude of the wife, educational and church facilities for children, etc.

"The Physician and His Community"—The growing consciousness of rural people toward health matters and the physician's place of leadership in that movement; the physician's responsibility in such projects as preschool roundups, rural organization activities, etc.; the satisfaction of being an important part of a community.

"Hospital Connections and Emergencies"—Increasing hospital facilities in rural communities; facilities open to the rural practitioner; hospital vs. home care; proximity to hospitals; consideration of efficiency of local hospital; rural medical and surgical emergencies encountered in rural practice.

"The Economics of Rural Practice"—Setting up



This is part of the group of Senior Medical Students who attended the banquet and last in the series of talks on rural practice.

practice in a rural community; office space available; housing; equipment; laboratory facilities; drug supplies; net and gross income as compared to that in metropolitan areas; use of time; types of practice, advantages and disadvantages of each; income from governmental agencies, etc.; the future of general practice.

Dr. Yantes' final discussion on "Types of Practice Encountered" covered such practical considerations as the number of patients treated by the rural practitioner; kinds and economic status of patients; the need for referrals and availability of various specialists; work that the general practitioner can undertake himself; country calls; a typical day in the life of a rural practitioner, etc.

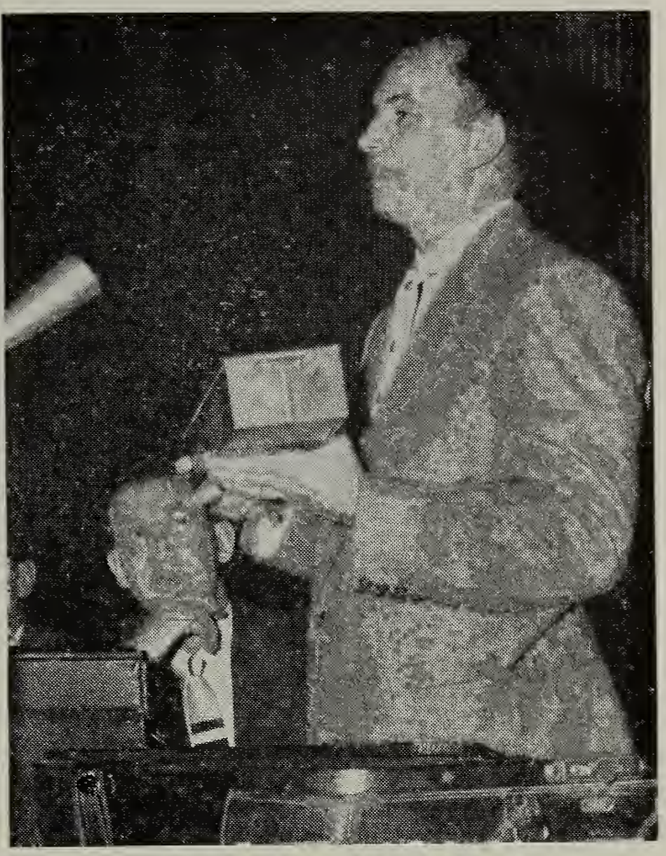


DR. WOODHOUSE

The talk given by Dr. Woodhouse on the subject, "A General Practitioner Looks at Medical Ethics," was a practical discussion of the high ideals and traditions of the profession entrusted to the physician in a rural community. Dr. Woodhouse, himself a rural practitioner for many years, has been accorded one of the highest honors that can be bestowed on a doctor, to be named a member of the Judicial Council of the American Medical Association.

Details concerning the series were worked out by Dr. Prior and Mr. Page.

Other programs of the Association to encourage general practice in smaller cities and rural areas include the Ohio State Medical Association Rural Medical Scholarship, now in its sixth year of operation and the Ohio State Medical Association locations service, which aids new physicians, returning medical officers, and physicians desiring to change areas.



Dr. Yantes (seated is Dr. Reiheld)



Dr. Fredericks

An important phase of the final meeting was a panel discussion giving the woman's viewpoint on a rural medical practice for the benefit of wives of medical students. Key persons in the discussion are shown below, left to right: Mrs. Robert E. Johnston, wife of the Senior Class president; Mrs. Robert E. Reiheld; Mrs. Edmond K. Yantes, chairman of the discussion group, and Dr. Emily Buchanan.



Ohioans on A.M.A. Program . . .

Advance Program Shows That Physicians from This State Played a Leading Role in 1954 Session Held June 21-25 in San Francisco

MORE than 70 Ohio physicians were on the program of the American Medical Association annual session in San Francisco, or otherwise took leading roles in activities. Hundreds of others traveled to the West Coast to attend the meeting—a large number by the Ohio State Medical Association Special Train.

The seven delegates of the Ohio State Medical Association to the A. M. A. House of Delegates were: Dr. Carl A. Lincke, Carrollton; Dr. William M. Skipp, Youngstown; Dr. George A. Woodhouse, Pleasant Hill; Dr. Herbert B. Wright, Cleveland; Dr. A. A. Brindley, Toledo; Dr. L. Howard Schriver, Cincinnati; and Dr. C. C. Sherburne, Columbus. Dr. Paul A. Davis, Akron, was delegate of the Section on General Practice to the A. M. A. House.

OHIOANS ON PROGRAM

The following physicians of Ohio took part in the program according to the advance program published in *The Journal of the A. M. A.*:

Dr. William A. Altemeier, professor of surgery, University of Cincinnati College of Medicine, discussed "Critical Reëvaluation of Chemotherapy in Surgery," before a general scientific meeting.

ANESTHESIOLOGY

Dr. Rolland J. Whitacre, Cleveland, opened discussion on a paper, entitled "The Use of Analgesics and Anesthetics for the Relief of Pain," before a joint meeting of the Sections on Anesthesiology, General Practice and Military Medicine. He is a member of the executive committee of the Section on Anesthesiology.

Dr. Carl E. Wasmuth, Cleveland, spoke on the subject, "Thiopental Anesthesia in Infants and Children," before the Section on Anesthesiology.

DERMATOLOGY

Drs. Harold N. Cole, James C. Harkin and Alan R. Moritz, Cleveland, took part in a discussion on "Pre-Columbian Osseous Syphilis Found at Kinishba and Vandal Cave, Arizona," before the Section on Dermatology and Syphilology.

Drs. Jan Schwarz and Leon Goldman, Cincinnati, spoke on the subject, "An Epidemiologic Study of North American Blastomycosis," before the Section on Dermatology and Syphilology.

DISEASES OF CHEST

Dr. Joseph C. Placak, Sr., Cleveland, is a member of the executive committee of the Section on Diseases of the Chest.

EXPERIMENTAL MEDICINE

Dr. Irvine H. Page, Cleveland, chairman of the Section on Experimental Medicine and Therapeutics, gave the chairman's address, entitled "The Dilemma's Horns."

Drs. J. Park Biehl and Richard W. Vilter, Cincinnati, spoke on "Effects of Isoniazid on Pyridoxine Metabolism," before the Section on Experimental Medicine and Therapeutics.

Dr. Albert B. Sabin, Cincinnati, opened discussion on a paper, entitled "Practical and Theoretical Considerations with Regard to Vaccination in Poliomyelitis," before a joint meeting of the Section on Experimental Medicine and Therapeutics and the Section on Internal Medicine.

> Because this issue of *The Journal* went to press before completion of the A. M. A. Session, detailed reports on the meeting, with highlights of official actions of the House of Delegates will be included in the August issue.

GASTROENTEROLOGY

Dr. John B. Hazard, Cleveland, took part in a panel discussion on "Pancreatitis," before the Section on Gastroenterology and Proctology.

GENERAL PRACTICE

Dr. Paul A. Davis, Akron, is delegate of the Section on General Practice to the House of Delegates of the A. M. A. and is a member of the executive committee of the Section.

INTERNAL MEDICINE

Dr. A. Carlton Ernstene, Cleveland, is secretary of the Section on Internal Medicine.

Dr. Bruce K. Wiseman, Columbus, opened discussion on the subject, "Treatment of Iron Deficiency Anemia," before the Section on Internal Medicine.

Dr. Erwin Levin, Cleveland, spoke on the subject, "Observations on the Diagnosis, Treatment and Course of Gastric Ulcer," before the Section on Internal Medicine.

Dr. Claude S. Beck, Cleveland, opened discussion on a paper, entitled "Pericardial Tamponade; Its Diagnosis and Treatment," before the Section on Internal Medicine.

E. N. T.

Dr. William H. Evans, Youngstown, spoke on "Office Treatment and Management in an Otolaryngologist's Office," before the Section on Laryngology, Otology and Rhinology.

Dr. Philip A. Weisman, Dayton, was co-speaker

on the subject, "Cancer and Chemodectoma of the Middle Ear and Mastoid," before the Section on Laryngology, Otology and Rhinology.

LEGAL MEDICINE

Dr. Alan R. Moritz, Cleveland, chairman of the Session on Legal Medicine, gave the chairman's address, entitled "Trauma, Stress and Coronary Thrombosis."

OPHTHALMOLOGY

Dr. Donald J. Lyle, Cincinnati, spoke on the subject, "Divergence Insufficiency," before a combined meeting of the Section on Ophthalmology with the Association for Research in Ophthalmology.

Dr. Lorand V. Johnson, Cleveland, is assistant secretary-treasurer of the Association for Research in Ophthalmology.

ORTHOPEDIC SURGERY

Dr. Nicholas J. Giannestras, Cincinnati, opened discussion on a paper, entitled "Transplantation of the Biceps Femoris Tendon to the Patella by the Medial Route in Poliomyelitic Quadriceps Paralysis," before the Section on Orthopedic Surgery.

PATHOLOGY & PHYSIOLOGY

Dr. John B. Hazard, Cleveland, opened discussion on a paper, entitled "Thyroid Nodules and Thyroid Cancers in 1,000 Consecutive Necropsies," before the Section on Pathology and Physiology.

Dr. Lawrence J. McCormack, Cleveland, talked on "Neurogenic Tumors (Olfactory Neuroepithelioma) of the Nasal Fossa," before the Section on Pathology and Physiology.

REHABILITATION

Dr. Walter M. Solomon, Cleveland, chairman of the Section on Physical Medicine and Rehabilitation, gave the chairman's address, entitled "Factors Influencing Progress in Physical Medicine and Rehabilitation."

Dr. Ralph E. Worden, Columbus, spoke on "Rehabilitation Centers—Planning, Administration, Personnel, Finance," before the Section on Physical Medicine and Rehabilitation.

Dr. Walter J. Zeiter, Cleveland, is secretary of the Section on Physical Medicine and Rehabilitation.

PREVENTIVE & INDUSTRIAL

Ohio played a dominant role in the Section on Preventive and Industrial Medicine and Public Health, with three Ohioans as key persons in the section, and seven on the program. Dr. John J. Phair, Cincinnati, is vice-chairman of the section; Dr. Frank Princi, Cincinnati, is secretary; and Dr. Paul A. Davis, Akron, representative to the Scientific Exhibit.

The following Ohioans were on the program of the Section on Preventive and Industrial Medicine and Public Health:

Dr. Morris S. Schulzinger, Cincinnati, subject: "The Accident Syndrome—A Clinical Approach";

Dr. H. S. Van Ordstrand, Cleveland, "Berylliosis — A Real but Preventable Industrial Disease";

Dr. Karl V. Kitzmiller, Cincinnati, "Treatment of Organic Lead Intoxication with EDTA";

Dr. Robert A. Kehoe, Cincinnati, opened discussion on the paper by Dr. Kitzmiller and another on the subject, "Experimental Administration of EDTA in Plutonium Poisoning";

Dr. Jacob Cholak, Cincinnati, "Air Pollution Measurement";

Dr. John E. Boysen, Wright-Patterson Air Force Base, "Aviation Medicine at the Crossroads"; and

Dr. Horace O. Parrack, Wright - Patterson Air Force Base, "Protection from Aircraft Noise."

RADIOLOGY

Dr. William James Engel, Cleveland, spoke on "Classification of Retroperitoneal Tumors as a Guide to Clinical Diagnosis," before a joint meeting of the Sections on Radiology and Urology.

Dr. Arthur T. Evans, Cincinnati, spoke on "Critical Evaluation of the Simultaneous Use of Various Contrast Methods in the Diagnosis of Retroperitoneal Tumors," before a joint meeting of the Sections on Radiology and Urology.

SURGERY

Dr. Robert M. Zollinger, Columbus, opened discussoin on a paper, entitled "Acute Conditions of the Gallbladder and the Common Duct," before the Section on Surgery, General and Abdominal. He is vice-chairman of the Section.

Dr. Claude S. Beck, Cleveland, spoke on "Operations for Coronary Artery Disease," before the Section on Surgery, General and Abdominal.

Dr. Bernard L. Brofman, Cleveland, opened discussion on Dr. Beck's paper.

Dr. Rupert B. Turnbull, Jr., Cleveland, spoke on "Technical Advances in the Surgical Treatment of Ulcerative Colitis," before the Section on Surgery, General and Abdominal.

Dr. Charles C. Higgins, Cleveland, is vice-chairman of the Section on Urology.

Dr. Leon Goldman was in charge of one of the surgery television color showings, entitled "Cholecystectomy."

SCIENTIFIC EXHIBITS

The following Ohioans presented scientific exhibits or otherwise took part in the Exhibit presentations:

Drs. Ralph G. Carothers, Nicholas J. Giannestras and T. H. Vinke, Cincinnati, took part in demonstrations of the Special Exhibit on Fractures.

Drs. Emmerich von Haam, Columbus, and John

NEW SERIES OF PUBLIC RELATIONS LEAFLETS AVAILABLE TO PHYSICIANS AND MEDICAL SOCIETIES

Here are some new and lively leaflets, free for the asking, that the physician can make available to his patients in the office, mail with statements, or otherwise distribute. The four catchlines on the leaflets are as follows:

You need a doctor—a **family doctor**—before illness strikes—**WHY WAIT?**
Beware of the healer who **guarantees a cure,** he may be a—**QUACK.**
Behind your doctor's prescription stands the A. M. A.—**ON GUARD.**
Modern research combines with medicine's experience to give you better—**HEALTH TODAY.**

They are excellent for use by Medical Societies for use at meetings, fairs and other public gatherings on medicine and health.

Each of the A .M. A. leaflets tells at a glance a story for the patient: (1) The progress made by medicine; (2) best ways to select a family doctor; (3) dangers of going to cultist healers, and (4) steps taken by the A. M. A. to evaluate drugs.

Order as many as you need from:

Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio

B. Hazard, Cleveland, took part in the Special Exhibit on Fresh Pathology.

Dr. A. Carlton Ernstene, Cleveland, took part in a question and answer conference on cardiovascular diseases, under the title "Pain Syndromes Due to Heart Disease."

Drs. Carl E. Wasmuth and Donald E. Hale, Cleveland Clinic, presented an exhibit, "Pentothal® Anesthesia in Children."

Drs. H. S. Van Ordstrand, Donald B. Effler, J. B. Hazard and L. J. McCormack, Cleveland Clinic, presented an exhibit, "Lung Biopsy."

Dr. E. A. Marshall, Huron Road Hospital, Cleveland, presented an exhibit, "Treatment of Peptic Ulcer with Excessive Neutralization and Unrestricted Diet."

Drs. William L. Proudfit and Joseph F. Dobosy, Cleveland Clinic, presented an exhibit, "Multichannel Tape Recording of Physiological Phenomena."

Dr. Harvey C. Gunderson, Toledo, was one of a team which presented an exhibit on "Structure and Functions of the External Nasal Pyramid."

Dr. Donald J. Lyle, Cincinnati, is on the exhibit committee of the Section on Ophthalmology.

Drs. John B. Hazard, George W. Crile, Jr., R. S. Dinsmore, W. A. Hawk and R. E. Kenyon, Cleveland Clinic, presented an exhibit on "Neoplasms of the Thyroid."

Dr. M. S. Schulzinger, Cincinnati, presented an exhibit, "The Accident Syndrome—a Clinical Approach."

Drs. J. C. Root, A. W. Humphries, V. G. DeWolfe and C. M. Greenwald, Cleveland Clinic, presented an exhibit, "Femoral Artery Occlusion."

Drs. Maurice D. Sachs and Philip F. Partington, Veterans Administration Hospital and Western University School of Medicine, Cleveland, presented an exhibit, entitled "Routine Operative Cholangiography."

Drs. Charles V. Meckstroth, Joseph L. Morton and Karl P. Klassen, University Hospital, Columbus, presented an exhibit, entitled "Bronchography as an Aid in the Diagnosis of Bronchogenic Carcinoma."

Drs. Claude S. Beck and David S. Leighninger, University Hospitals, Cleveland, presented an exhibit, "Operations for Coronary Artery Disease."

Michigan State Medical Meeting Planned for Fall

The eighty-ninth annual session of the Michigan State Medical Society will be held in the Sheraton-Cadillac Hotel, Detroit, September 29-October 1. Six assemblies and 14 section meetings will feature 26 prominent lecturers selected from a variety of important medical centers.

Two Ohio physicians are listed among guest physicians on the program. They are Dr. Max M. Zinninger, Cincinnati, and Dr. George Crile, Jr., Cleveland.

Physicians of Ohio and other neighboring states are invited. Additional information may be obtained from the Michigan State Medical Society, 606 Townsend St., Lansing, Mich.

Gallipolis—The Holzer Hospital recently was presented at $5,000 contribution by the Vanadium Corporation of America, in behalf of the Company's employees in the vicinity.

Federal Legislation . . .

Status of Major Proposals of Interest to Medical Profession Is Reviewed in Roundup Story Issued by Washington Office of A.M.A.

THE Washington Office of the American Medical Association issued the following roundup on the status of bills before the United States Congress as this issue of *The Journal* went to press.

The controversial health reinsurance issue has come back into prominence, and under conditions that make the whole question about as complicated as it can get. The bill would have the federal government underwrite voluntary health insurance plans if they agree to experiment with risks not usually covered.

Although this measure is a major part of President Eisenhower's health program, it became bogged down in the House Interstate and Foreign Commerce Committee when widespread opposition developed. Then the committee chairman, Rep. Charles E. Wolverton (R.-N. J.), turned to one of his favorite subjects, a plan for federal guarantee of private loans to health facilities for construction and equipment. This bill, however, was not supported by the administration.

POLITICAL MANEUVERS

In an effort to placate the opposition, Mr. Wolverton offered to eliminate a number of objectionable features from the mortgage guarantee bill. At the same time there were reports that he proposed to merge this bill with the administration-supported reinsurance bill. Meanwhile, Henry J. Kaiser made two special trips to Washington to help out his friend, Mr. Wolverton, by putting his weight behind the mortgage loan idea. That was not surprising, inasmuch as Mr. Kaiser had helped to draw up the bill, which would greatly benefit health centers such as those started on the West Coast by the Kaiser Foundation.

Mr. Kaiser, saying he was producing a film to promote the mortgage loan plan, went to the unusual extent of making a direct appeal to Washington news correspondents to write favorable copy about the bill.

PRESIDENT'S ACTIVITIES

While these Wolverton-Kaiser maneuverings were taking place on the mortgage bill, it became apparent that President Eisenhower was not ready to abandon the reinsurance idea. He called a number of executives of major life insurance companies to the White House to try to impress them with the merits of reinsurance and in other ways indicated he still wanted to see the bill passed this session. Secretary Hobby, whose original testimony for reinsurance had been restrained, also joined in the last-minute campaign. But it appeared the tangle might be too complicated even for Mr. Eisenhower to unravel before adjournment.

OTHER PARTS OF PRESIDENT'S PROGRAM

Other parts of the Eisenhower health program were moving through Congress, even though some were off schedule. Legislation to expand the Hill-Burton hospital construction program cleared what might have geen a serious obstacle when it was reported out by the Senate committee. Compared with the House bill, the Senate bill gave more discretion to state health authorities in use of funds for constructing facilities for the chronically ill, for nursing homes, and for health centers. However, the Senate would require that funds earmarked for rehabilitation centers be used for the stated purpose. The Senate also would rule out the possibility of U. S. grants to centers devoted solely to treatment. Unless the facility could qualify as a diagnostic center, or a diagnostic-treatment center, it could not be eligible under the Senate bill. This safeguard was not in the House bill.

Of the remaining legislation of interest to the medical profession, the status at this writing was about as follows:

The doctor draft amendment, to strengthen Defense Department's hand in dealing with physicians who might be security risks, had passed the Senate, been reported by the House committee, and was almost a law. Also about to be enacted was a provision liberalizing medical expense deductions from taxable income.

The House-passed social security bill, with the compulsory coverage of physicians eliminated, was before the Senate Finance Committee, where anything could happen. One bill enacted into law prohibits the shipment of fireworks into a state where fireworks are illegal.

House Ways and Means Committee is considering a bill which would require all employers, even those with only one employee, to participate in the federal-state unemployment compensation program.

House Veterans Affairs Committee has approved a two-year extension of the Korean GI Bill of Rights.

Marion—Dr. Bret B. Hurd was named Marion County health commissioner to succeed Dr. Neuman Sifritt, who retired after serving as county coroner since the post was created in 1920.

Annual Hospital Survey . . .

Ohio Passes Million Mark in Number of Admissions to Hospitals for Year, A. M. A. Report Shows; Births in Hospitals Still on Increase

APPROVED hospitals in Ohio set an all-time record in service to the public in 1953 by admitting well over a million patients and by having approximately 92.2 per cent of Ohio's all-time number of births in hospitals.

Ohio was somewhat ahead on both counts of the national trend which also showed a record number of births and admissions to hospitals in 1953, according to the annual report of the A. M. A.'s Council on Medical Education and Hospitals, in the May issue of *The Journal of the A. M. A.*

Ohio's total number of births in 1953 was 210,727, of which 194,300 were in hospitals. In the nation, there were 3,307,182 births in hospitals, or 84 per cent of the estimated total of 3,910,000.

Hospital admissions in Ohio totaled 1,019,581, compared to 951,283 for the previous year. The national total of admissions was 19,869,061, compared to 18,914,847 the previous year. It was an all-time record for Ohio and for the nation. Ohio's total of admissions were exceeded by only five states—New York, 1,964,620; California, 1,454,637; Pennsylvania, 1,272,502; Illinois, 1,179,466; and Texas, 1,097,091.

To aid in caring for this influx of nearly a million new admissions, the 6,840 hospitals registered with the A. M. A. increased their bed capacity by 31,399 to 1,573,014.

Ohio also had an increase in bed capacity. In this state, 254 hospitals on the approved list had a bed capacity of 73,836, compared to 251 approved hospitals in 1952 with a bed capacity of 72,344—an increase of 1,492 beds. In 1953, there were 4,631 bassinets, an increase of 208 over the previous year.

SOME NATIONAL STATISTICS

The national total includes 1,113,004 beds in governmental hospitals and 460,010 in nongovernmental hospitals. The nongovernmental group cared for 74 per cent of all the patients, however.

The decline in the number of persons seeking treatment in tuberculosis sanitoriums was from 109,925 in 1952 to 108,471 in 1953. There were 107,181 cases of this type in 1951.

Admissions throughout the nation to psychiatric hospitals for the year jumped from 312,252 to 328,336, which was a significant rise considering that in the period from 1950 through 1952 there was an increase of only slightly more than 5,000. The report stated:

While these institutions received only 1.7 per cent of the patients admitted, they maintained an average daily census of 719,335, which is greater than the combined patient load in all other registered hospitals. Thus, the average daily census is more fully indicative of the volume of service in the psychiatric field, where longer periods of hospitalization are necessarily required.

The psychiatric hospitals in the nongovernmental group listed 87,794 admissions in the last year, whereas the governmental section reported 240,542, including 190,694 in the psychiatric hospitals operating under state control.

OCCUPANCY RATE

The bed occupancy rate was highest in the psychiatric field, too, with 96.0 per cent. In other fields, isolation units had only a 47.2 per cent occupancy, tuberculosis 84.6, and general hospitals had a reduction from 74.1 per cent to 73.0. In this connection, the governmental general hospitals reported an average bed occupancy of 73.3 per cent, and the nongovernmental general hospitals 72.7.

"It also should be noted," the report said, "that an average of 80-85 per cent is usually regarded as the maximum limit of operating efficiency in general hospitals. For all practical purposes, therefore, a general hospital reporting 80 per cent or more may be regarded as operating at capacity level."

Of the 6,840 hospitals accepted for A. M. A. registration, 4,704 are nongovernmental units and 2,136 are under governmental control. When classified by control, the governmental division includes 392 federal hospitals, 550 state institutions, 713 county hospitals, 396 municipal and 85 city-county.

The average daily census increased in 1953 to 1,332,551 from 1,309,377 in 1952. This increase is in line with a steady rise which has occurred since 1949. The daily census includes 995,866 in the governmental hospitals and 336,685 in the nongovernmental group. Here again the treatment of psychiatric cases affected the governmental load with 623,105 in the state hospitals alone.

STAY PER PATIENT

"In the last year the average length of stay per patient was reduced in all general hospital divisions except the state group. The reduction was most prominent in the federal general hospitals, which reported 23.6 days compared with 26.2 in 1952. While the state hospital rate increased from 14.1 to 14.8 days, the average stay was reduced from 11.9 to 11.2 in the county units,

APPROVED HOSPITAL FACILITIES IN OHIO DURING 1953

Control	No. of Hospitals	Beds	Bassinets	Patients Admitted	Average Census
Federal	6	4,751	20	36,958	4,308
State	27	37,233	56	31,916	34,456
County	33	5,612	270	41,732	4,433
City	16	3,051	395	76,590	2,326
City-County	3	171	51	6,900	117
Total Governmental	85	50,818	792	194,096	45,640
Church Related (nonprofit)	54	10,179	1,726	376,223	8,441
Nonprofit Associations	97	11,943	2,083	440,676	9,449
Total Nonprofit	151	22,122	3,809	816,899	17,890
Individual and Partnership	8	185	7	1,749	133
Corporations (Profit Unrestricted)	10	711	23	6,837	589
Total Proprietary	18	896	30	8,586	722
Total Nongovernmental	169	23,018	3,839	825,485	18,612
Grand Total	254	73,836	4,631	1,019,581	64,252

from 11.7 to 11.5 in the municipal hospitals, and from 9.0 to 8.8 in the city-county group," the report noted.

The average length of stay in all general hospitals was reduced from 9.8 days in 1952 to 9.3 days in 1953. Governmental general hospitals had a reduction from 16.4 to 15.1 and nongovernmental from 7.5 to 7.4.

ADMISSIONS BY TYPE

For every 1,000 admissions in 1953, 941 were assigned to general hospitals, 17 to psychiatric institutions, 5 to tuberculosis sanatoriums, 4 to maternity hospitals, 3 to industrial units, 6 to eye, ear, nose and throat, 8 to children's hospitals, 2 to orthopedic, 1 to isolation, 2 to convalescent units, 6 to hospital departments of institutions, and 4 to other hospitals.

OHIO HOSPITALS BY TYPE

Following are the number of approved hospitals in Ohio and the number of beds by type of service offered: General, 165 with 27,810 beds; nervous and mental, 29 with 38,157 beds; tuberculosis, 24 with 4,749 beds; maternity, 9 with 234 beds; industrial, 1 with 18 beds; eye, ear, nose and throat, 1 with 6 beds; children's, 3 with 546 beds; orthopedic, 3 with 180 beds; convalescent and rest, 9 with 1,020 beds; hospital departments of institutions, 7 with 395 beds; all other hospitals, 3 with 721 beds; total 254 with 73,836 beds.

NURSING PERSONNEL IN OHIO

The following information regarding nursing personnel and schools of nursing in Ohio was given in the report: Student nurses, 6,103; accredited schools of nursing, 58; schools offering affiliated courses only, 14 with 1,241 students; administrative nursing personnel, 456; full-time instructors, 433; supervisors and assistant supervisors, 1,043; head nurses and assistant head nurses, 1,860; general duty nurses full time, 5,353; general duty nurses part time, 3,076; nurses not classified, 293; total graduate nurses, 12,514; private duty nurses, 1,326.

The foregoing figures show an increase in the number of Ohio student nurses of 230 and in the number of graduate nurses of 837 over the previous year.

The following information is given on practical nurses and auxiliary personnel in Ohio: Schools of practical nursing, 7; practical nurse students, 194; practical nurses employed, 1,611; attendants, 5,678; nurses' aides, 8,483; ward maids, 1,258; orderlies, 1,075.

The following information is given on technical personnel in Ohio hospitals: Medical technologists full time 1,063, part time 181; x-ray technicians full time 574, part time 91; physical therapists full time 171, part time 15; occupational therapists full time 145, part time 21; medical record librarians full time 260, part time 33; other medical record personnel full time 441, part time 91.

Subscription Rate to The Journal and Single Copy Price Increased

The annual subscription price for *The Ohio State Medical Journal* was increased from $3.00 to $5.00 by action of The Council at its May 23 meeting, effective immediately. The cost of single copies also was increased from 30 cents to 50 cents. Current subscriptions will continue at the old rate until expiration.

This is the first increase in subscription rates for *The Journal* in many years, in spite of continuous increases in production costs. The new rates are in keeping with prevailing rates of other publications in the same class as *The Journal.*

The increase does not affect members of the Association, who receive *The Journal* as part of the services covered by their dues.

Between ages 13 and 19, the death rate among boys rises from 0.64 to 1.31 per 1,000; while among girls it increases from 0.37 to only 0.56 per 1,000.—Metropolitan Life.

Doctors and Educators Get Together . . .

First Ohio Conference on Physicians and Schools Gets Enthusiastic Support of Medical Profession on State and County Society Levels

THE first Ohio Conference on Physicians and Schools, held at Lake Hope Lodge, May 11-13, received the enthusiastic support and participation from county medical society school health chairmen and the School Health Committee of the Ohio State Medical Association.

The conference was an invitational affair, planned and conducted on the basis of a "team approach." Key educators, administrators, public health officials and the chairmen of the county medical society school health committees from ten selected counties were asked to attend.

Only two speakers were scheduled on the program. A keynote address by Delbert Oberteuffer, chairman of the department of physical education, Ohio State University, opened the program; and a closing summary was presented at the final general session by Dr. John D. Porterfield, at that time the Ohio Director of Health.

The bulk of the time was spent in small meetings involving those attending from each of the ten counties, with consultation on local problems available from a selected group of resource people, including Dr. Donald A. Dukelow, consultant in health and fitness, Bureau of Health Education, American Medical Association.

Panel discussions on general problems, and on "working together" featured two of the five general sessions. The film "School Health in Actions," was reviewed and discussed at another.

General purpose of the conference was to build mutual understanding on a local basis among physicians, educators, public health people, and others, for the stimulation of efforts in sound school health programming throughout the State.

COUNTY REPRESENTATIVES

Physicians representing county medical society school health committees included: Dr. Margaret Belt, Lima, Allen County; Dr. H. L. Sowash, Sandusky, Erie County; Dr. H. M. Boocks, Logan, Hocking County; Drs. William T. Bacon and R. S. Postle, London, Madison County.

Dr. Charles L. Kagay, Dayton, Montgomery County; Drs. Russell L. Oyer, Sugarcreek and Elizabeth Rowland-Aplin, Gnadenhutten, Tuscarawas County; Dr. William S. Hawn, Marietta, Washington County; Dr. William S. Rothe, Bowling Green, Wood County.

STATE ASSOCIATION COMMITTEEMEN

Members of the Ohio State Medical Association Committee on School Health participating in the meeting were: Dr. Thomas E. Shaffer, Columbus, Chairman; Dr. Homer B. Thomas, Gallipolis, past-chairman; Dr. Walter Felson, Greenfield; Dr. Walter T. Heine, Circleville; Dr. T. L. Light, Dayton; Dr. Robert A. Lyon, Cincinnati; Dr. Margaret O'Neal, Zanesville; Dr. J. M. Painter, Kent; Dr. Carl L. Petersilge, Newark; Dr. Carl A. Wilzbach, Cincinnati.

Drs. Sowash, Oyer, Belt, and Rothe are members of the School Health Committee of the Ohio State Medical Association in addition to representing county medical society committees.

HEALTH COMMISSIONERS

Health Commissioners participating included: Dr. G. E. Miller, Allen County; Dr. N. Berneta Block, Sandusky-Erie County; Dr. Robert A. Vogel, Madison, Union, Delaware and Morrow Counties; Dr. W. H. Willis, Lake County; Dr. B. J. Allison, Jackson County; Dr. J. F. Weber, Washington County, Dr. Boocks; and Dr. N. A. Dyer, Pike, Ross, and Fayette Counties and Chillicothe; and Dr. O'Neal.

The meeting was sponsored by the State Planning Committee for Health Education, a voluntary association of people engaged in health education, including representatives of the State Departments of Health and Education, and the Division of Mental Hygiene; The Ohio State Medical Association; the Ohio State Dental Association; The Ohio Farm Bureau Federation; the Ohio Tuberculosis and Health Association; The Health Education Coordinators, teachers of health teachers, of the five state Universities are members, as are the Health Education Consultants of the Ohio Department of Health.

The conference was financed by the following organizations: The Ohio State Medical Association, the Ohio Education Association; The Ohio State Heart Association; The Ohio Tuberculosis and Health Association; and the Ohio Department of Health.

Sewall O. Milliken, chairman of the State Planning Committee for Health Education, served as general chairman and Hart F. Page, Secretary to the Committee on School Health, Ohio State Medical Association, was chairman of Arrangements.

At the end of November, 1953, there were 20,401,000 veterans in civil life in this country according to the Veterans Administration. This number included 15,433,000 veterans from World War II, 3,281,000 from World War I, and 1,687,000 from other wars and Regular Establishment.

You and Your Public . . .

Editor of the Associated Press Gives Some Pointers on Just What Good Relations with the Press Means to the Doctor and the Public

THE review of a talk by Alton L. Blakeslee, science editor of the Associated Press concerning physician-newspaper cooperation appeared recently in *The Diplomate*, publication of the National Board of Medical Examiners. The address was delivered at the annual meeting of the Syracuse University Medical Alumni Association.

In speaking to the 250 physicians who returned for the annual Alumni Day, Mr. Blakeslee emphasized the fact that mutual trust and respect between doctors and newspapers is important for the best reporting of medical news.

ACCURACY, THE WATCHWORD

"You want strict accuracy and so do the newspapers. Accuracy is our hallmark. We are hurt by inaccuracies as much as you are. We want to avoid them and believe that they can be avoided largely by greater co-operation between doctors and newsmen."

Blakeslee cited several ways in which the doctors could help the press in keeping accuracy at a high level.

One, he said, was in talking openly and frankly with the reporter. If there is something newsworthy going on, the reporter will get it, despite obstacles. If the sources of information refuse to talk, reporters must get their facts second hand and check the details as best they can. Here is where inaccuracies creep in.

Another means of co-operation is in helping the writer understand the technical parts of the story. Technical language must be interpreted for the reading public.

If a reporter's questions bring you up against problems of medical ethics, Blakeslee suggested the doctor explain frankly why he can't answer. This will make sense to the reporter.

Frequently newsmen will ask their source of information to review copy to make sure they have not made mistakes in emphasis or wording. The doctor's safeguard is in making himself understood during the interview.

BENEFITS TO THE DOCTOR

At this point Mr. Blakeslee said the doctors might well ask what benefits the medical profession would obtain from this co-operation with the newspaper. He listed four.

1. The popularity of medical news is creating a healthier nation. The more informed we are about health rules, good diets and various signals of sickness, the more likely we are to practice positive health rules and consult a doctor for regular check-ups, or for investigation of suspicious symptoms.

2. The public is coming to understand the medical profession better. We trust what we understand and distrust what we don't understand.

3. Today most research in medicine depends on contributions from the public. People are far more willing to support research if they know what is being done, why research goes slowly, and what could be achieved through greater support of research.

4. Sometimes news stories from a medical convention tell the doctor of new advances which could be helpful to one of his patients. The story might precede full publication in a medical journal by months. It would tell only essentials, but could tell what doctor to contact to learn more about it.

A survey of managing editors shows medical news most popular over all branches of science. With the press and medical profession co-operating fully, we can go far in winning still greater health benefits for the American public, according to Blakeslee.

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since May 7, 1954. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY

James E. Bennett, Cleveland
Robert E. Campbell, Cleveland
Theodore P. Day, Cleveland
Paul D. DeWitt, Cleveland
Gabriel P. Escobar, Garfield Hts.
Francis J. Harvey, Cleveland
James W. Hepplewhite III, Cleveland
Nicholas A Hruszkewycz, Cleveland
Vencel Jakab, Cleveland
Frank E. Nulsen, Cleveland
Indrikis E. Parups, Cleveland
Walter Pavluk, Cleveland
Joseph Skrha, Cleveland
Joseph A. Solomayer, Cleveland
William V. Trowbridge, Cleveland

FRANKLIN COUNTY

Robert H. Kuhn, Columbus
Sarah Brackney Long, Columbus
James H. McClure, Columbus
Leonards Primanis, Columbus
Mark Louis Saylor, Columbus
James Russell Scheip, Columbus
Robert B. Stevenson, Columbus
Harry D. Tripp, Columbus

HAMILTON COUNTY

Charles O. Carothers, Cincinnati

LORAIN COUNTY

Eugene M. Socha, Amherst
Roman Stetkevich, Lorain

MAHONING COUNTY

Harold Segall, Youngstown
Anthony J. Telego, Youngstown

MONTGOMERY COUNTY

Forrest W. Freeman, Dayton

PUTNAM COUNTY

James Sawyer, Leipsic

SENECA COUNTY

Stephen Markey, Fostoria

STARK COUNTY

Thomas H. Hoover, Canton
Ruth Stekert, Canton

SUMMIT COUNTY

Robert J. Hemphill, Barberton
William Kraus, Akron

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

PORTERFIELD TAKES ON BIG NEW JOB

Decision of Dr. John D. Porterfield to accept the appointment of Governor Lausche as director of the new Ohio Department of Mental Hygiene and Corrections has been viewed by his many friends within and outside the medical profession with mingled emotions.

Porterfield has done an outstanding job as director of the Ohio Department of Health. Those primarily interested in that particular field are reluctant to see him vacate a position he has filled so well. On the other hand, they realize that he has the know-how to do an equally efficient job as head of the mental hygiene and corrections agency and to get it off to a flying start.

By and large, the medical profession has given Dr. Porterfield fine cooperation during his tenure as director of health and has received fine support and cooperation from him. It is hoped that this relationship will continue. In his new position, Porterfield will need the working cooperation of physicians in private practice. His record indicates that he, on the other hand, will endeavor to run the new department in line with sound medical procedures and policies. His responsibilities will be big and his problems numerous. Let's give him the support he needs. We are sure he will welcome it.

FEW DOCTORS RETIRE AT AGE 65, DATA SHOW

Those who have been following the course of the new Social Security Bill in the current Congress, especially that portion which would have compelled physicians to be covered but which was eliminated by the House Ways and Means Committee and supported by the vote of the House, will be interested in the following statistics uncovered by the A. M. A.

Of the 22,296 physicians in the age group of 65-74 in the United States as of April, 1950, 18,770 or 84.2 per cent, were in active private practice. Commenting on the figure, the *Journal of the A. M. A.* said editorially:

"Only 15.8 per cent were not engaged in active private practice. Among these 3,526 not in active private practice were housewives and others who had practiced for only a few years, if any, and several hundred who were still employed by private or public employers; still others had retired from private or public employment, probably on a pension financed in whole or in part by the employer . . .

"If the pattern of 1950 is continued, eight or nine physicians out of 10 would be required to pay social security taxes but would receive no pension from age 65 to 75."

The battle to exclude physicians from Old Age and Survivors Insurance coverage was led by Congressman Thomas Jenkins, Ironton, Ohio, against big odds, including pressure from the White House for their inclusion. Exclusion of physicians is supported by official actions taken by the A. M. A. House of Delegates and the Ohio State Medical Association House of Delegates. Some physicians don't agree with this stand, which, of course, is their right and privilege. If Congress wants to make coverage of physicians a voluntary matter on the part of individual doctors, many will not object, in our opinion. But, we believe that most physicians, who have thought over the matter carefully, are opposed to being compelled to participate in the Social Security program, on the grounds that benefits would not be commensurate with the taxes paid and that they can get a better deal by arranging their own retirement program. This will be especially true if Congress will enact the Jenkins-Keogh Bills which would provide income tax relief for self-employed persons participating in a voluntary retirement insurance program.

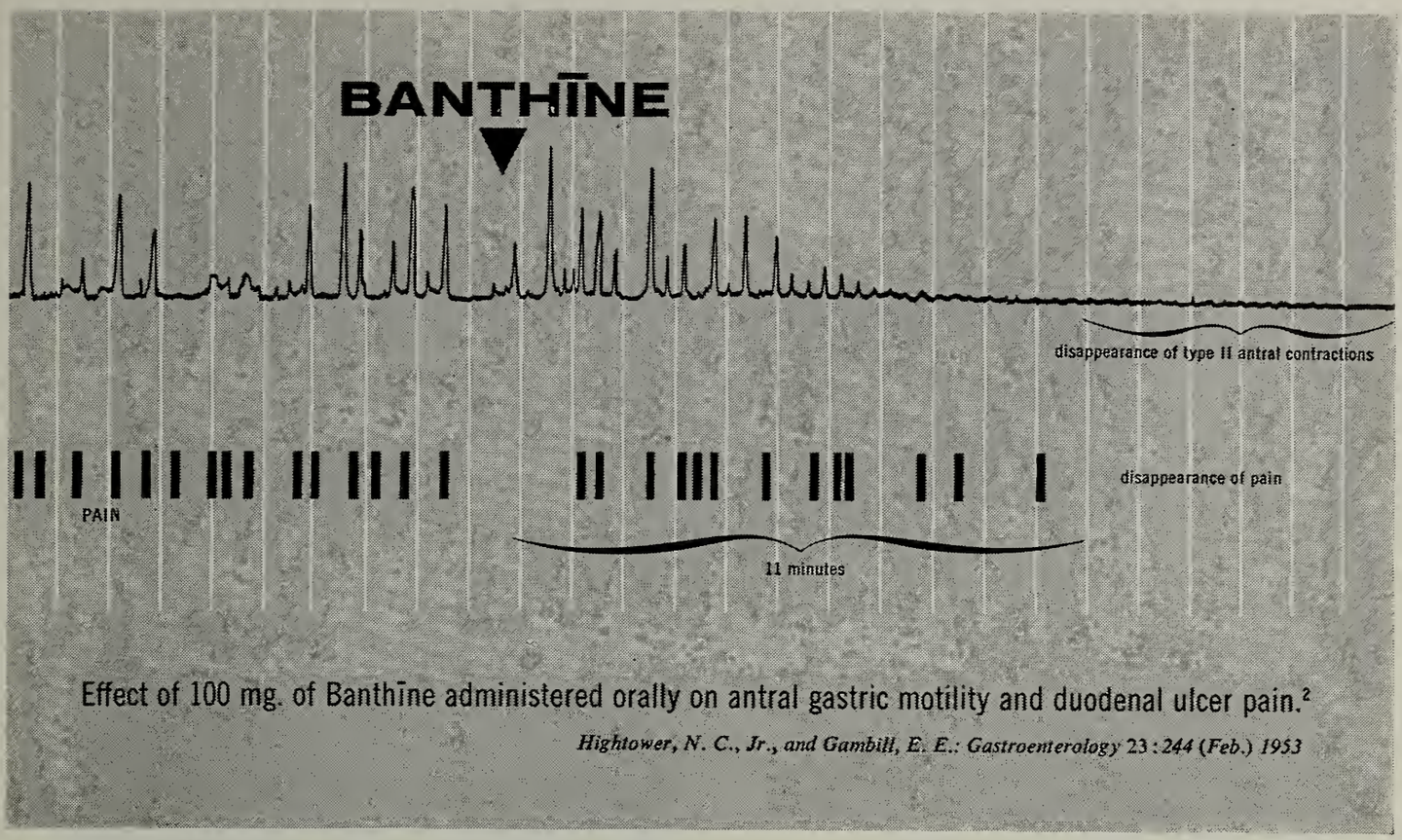
BRICKER SAYS FIGHT FOR PROPOSAL TO CONTINUE

Many Ohio physicians who wanted the so-called Bricker Amendment on international treaties and agreements adopted, will be pleased to know that Senator John W. Bricker, Ohio, plans to continue the fight.

Following are several excerpts from a recent letter sent by Senator Bricker to those who wrote him on his proposal:

"First, let me thank you from the bottom of my heart for your words of encouragement in this fight to prevent the sovereignty and the Constitution of the United States from being undermined by treaty or by executive agreement. During long weeks of Administration pressure and misrepresentation of the amendment by hostile segments of the press, your expression of support was most gratifying. It strengthened my determination not to compromise on the basic principles of the amendment.

"Secondly, let me assure you that the fight for an adequate treaty-control amendment has only just begun. We will win because you and millions of other patriotic Americans do not believe that treaties of the UN and its specialized agencies or executive agreements should



Effect of 100 mg. of Banthīne administered orally on antral gastric motility and duodenal ulcer pain.[2]

Hightower, N. C., Jr., and Gambill, E. E.: Gastroenterology 23:244 (Feb.) 1953

Banthīne® Reduces Hypermotility and Hyperacidity in Peptic Ulcer

A recent evaluation of anticholinergic therapy in peptic ulcer emphasizes the fact that now the profession has at its disposal agents that are "effective in reducing both secretory and motor activity of the stomach."

The effect on motor activity is generally more pronounced and less variable than on secretion; pain relief is usually prompt; a high degree of effectiveness is noted in ambulatory ulcer patients.

Ruffin, J. M.; Texter, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

With its proved anticholinergic effectiveness, Banthine has been found extremely useful in the medical management of active peptic ulcer, whether duodenal, gastric or marginal.

The immediate increase in subjective well-being and the simplicity of the Banthine regimen assures patient cooperation. The recommended initial therapeutic dose is 50 or 100 mg. (one or two tablets) every six hours around the clock, with subsequent individual adjustment. The usual measures of diet regulation, rest and relaxation should be followed.

Banthine is effective in other conditions caused by excess parasympathetic stimulation. These include hypertrophic gastritis, acute and chronic pancreatitis, biliary dyskinesia and hyperhidrosis. Banthine is contraindicated in the presence of glaucoma and should be used with caution in the presence of severe cardiac disease or prostatic hypertrophy.

Banthine® bromide (brand of methantheline bromide) is supplied in scored tablets of 50 mg. and in ampuls of 50 mg. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

be used to regulate our purely domestic affairs. Powers of domestic legislation must be retained in the Congress and in the State legislatures.

"Many of you requested in your letters explanatory material relative to the need for a treaty-control amendment. I have attempted to fill those requests. For additional material, I suggest that you write to: Foundation for Study of Treaty Law, Room 422, 1001 Connecticut Avenue, N. W., Washington, D. C., or Mr. Frank E. Holman, Hoge Building, Seattle 4, Washington.

"In addition, many of you asked for suggestions as to how you might play a more active part in this fight for constitutional protection against the treaty power. The amendment has been endorsed by the major national legal, medical, business, veterans', patriotic, and farm organizations. As a member of one of those groups, you can participate actively in this phase of their work.

"Also, one organization has been formed for the exclusive purpose of securing favorable action on the amendment. It is known as the Vigilant Women for the Bricker Amendment, Post Office Box 98, Hinsdale, Illinois. I know you will find that their work merits your support.

"Remember that the fight has only just begun; that the issue is not dead; and that eventually we will win because we are right."

MAY TAKE BUGS OUT OF "STRIKE IT RICH" SHOW

For some time, physicians have been disturbed by the "Strike It Rich" TV show whose participants many times have left the impression that high medical bills have been the main cause of their difficulties. The A. M. A. Public Relations Department conferred with the producer of the show. The result was an agreement that such cases would be cleared in advance with the A. M. A. and it in turn would confer with area medical societies as to the facts and the basis for the claims of participants where medical bills are involved. Investigation of several cases revealed little basis for the claims made by the participants and they were declared inelegible to participate.

This is Public Relations in action. It's surprising how much can be accomplished when parties are willing to sit down, talk over matters and reach agreements before things happen. Try it with your patients; try it with groups in your community.

PURPOSE OF INTERN MATCHING PLAN CLARIFIED

There has been some confusion and misunderstanding regarding the National Intern Matching Program. Some have the opinion that it has kept certain hospitals from securing interns—or as many as they want.

The following statement which clarifies the purpose, attitude and philosophy of the intern matching program was sent recently by John M. Stalnaker, director of the program, to the A. M. A. Committee on Internships:

"The National Intern Matching Program has now completed three years of successful operation. This agency is operated jointly by the A. M. A., the hospital associations and the Association of American Medical Colleges. Its sole purpose is to facilitate the orderly placement of senior medical students in first year internships. The plan preserves in the American tradition free choice by both hospital and student as well as their bargaining rights. It does not interfere with, but gives effect to the expressed preferences of both groups. The program does not approve, restrict or in any way control the internships offered by hospitals. It does not allocate interns. Each student gets his most desired internship if that hospital wants him. Each hospital gets every man that it wants, up to the number it specifies, who wants to go there."

MORE CAREFUL BLOOD PACKAGING URGED

A suggestion found in one of Dr. George F. Lull's A. M. A. secretary's bulletin of recent date is something which each physician should comply with. Here it is:

"An assistant postmaster in Chicago phoned my office recently and complained that many doctors are mailing blood specimens in glass vials placed in metal screw-topped cardboard tubes to private and governmental laboratories and, because of carelessness in screwing the tops on securely, the vials slip from the tubes, are broken, and the blood stains other mail. He pointed out one important fact from the doctor's viewpoint; if the postal employee re-inserts the vials in the tubes, who knows whose blood goes into whose tube?

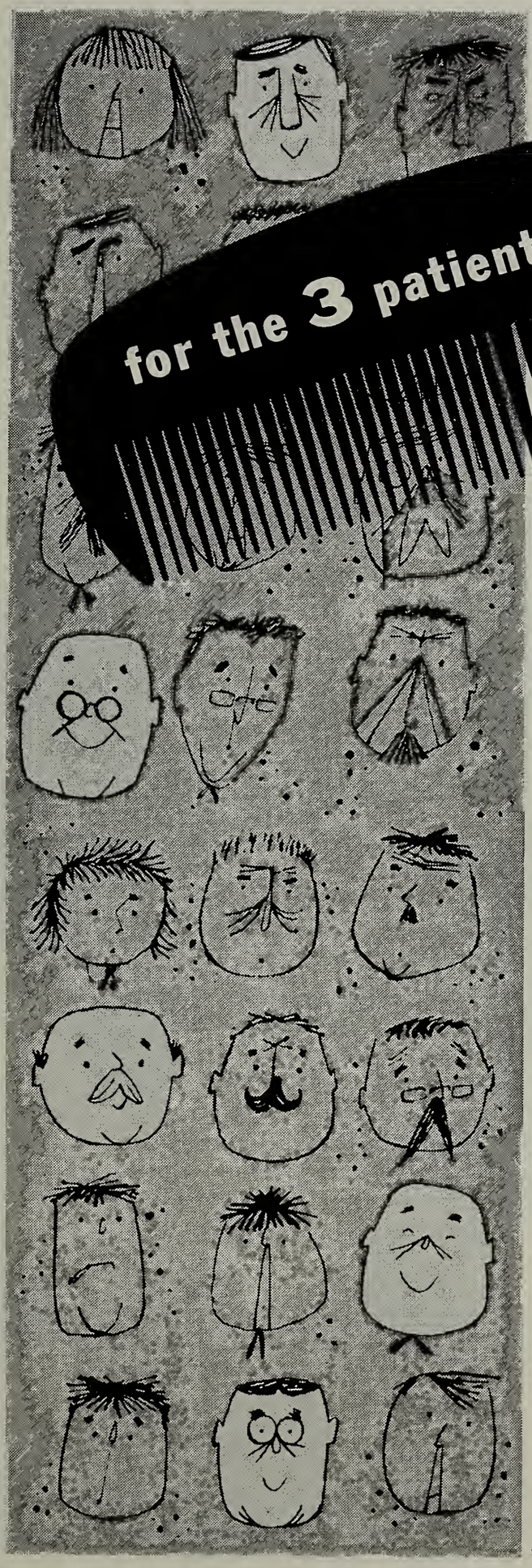
"The assistant postmaster said the same trouble exists in other postal centers and urged us to publicize what he called 'this dangerous nuisance.'

"He urged doctors to place an adhesive strip (not scotch tape) across the metal top and down the sides of the container. This, he said, will prevent the insecurely screwed tops from coming off."

GOOD P. R. WORK IN MONTGOMERY COUNTY

Public Relations Committee of the Montgomery County Medical Society is making a survey of society members to find out how many participate actively in local community and civic organizations and projects. This is an exceedingly worthwhile undertaking for many reasons, among them the following: It will give the society leads as to medical contacts with various groups. It certainly will serve as a reminder to physicians about their obligation to participate in community affairs. It will encourage physicians who do participate, to increase their efforts.

What's the situation in your county? Might be interesting to find out.



who have
seborrheic dermatitis
of the scalp

FOR the scalp-scratchers, shoulder-brushers and comb-clutterers, there's welcome relief with SELSUN Sulfide Suspension.

Published reports on more than 400 cases[1 3] show that SELSUN completely controls seborrheic dermatitis in 81 to 87 percent of all cases, and in 92 to 95 percent of common dandruff cases. It keeps the scalp free of scales for *one to four weeks*—relieves itching and burning after only two or three applications.

SELSUN is remarkably simple to use. Your patients apply it and rinse it out while washing the hair. It takes little time. No complicated procedures or messy ointments. Ethically advertised and dispensed only on prescription. In 4-fluidounce bottles with complete directions on the label.

Abbott

prescribe...

SELSUN®
SULFIDE *Suspension*

(SELENIUM SULFIDE, ABBOTT)

1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

1-348-54

Ethics and Medical Advertising . . .

Committee of Cincinnati Academy Interprets Code of Ethics in Regard To Signs, Newspaper Notices, Mailed Cards to Patients, and the Like

THE following article from the *Cincinnati Journal of Medicine* shows what one county society has done to arrive at local uniformity in regard to ethical medical advertising. The article is a report from a local committee, which by approval became policy of the Cincinnati Academy. As stated here, the local medical society is the best group to determine local policy, however, the report is of general educational value to all physicians.

* * *

The Public Relations Subcommittee on Medical Advertising met on February 17, 1954, to discuss certain aspects of the Code of Medical Ethics and to prepare rules on signs and advertising. The American Medical Association states that its "Principles of Medical Ethics are not laws to govern, but are principles to guide to correct conduct." Chapter 1, Sections 4 and 5, on the principles of medical ethics express the ethical principles and policies of the American Medical Association. Section 4 states that "disregard of local customs and offenses against recognized ideals are unethical." The Judicial Council states that the local medical society is the group best able to determine what is local custom and what advertising is contrary to good taste and recognized ideals. Our committee, therefore, presents the following recommendations to the Council of the Academy of Medicine of Cincinnati for consideration and alteration or approval:

SIGNS

1. The use of signs by the physician to make known his identity, location and specialty, is proper and acceptable. These signs should be dignified and conservative both in design and color.

2. Illumination of a sign is acceptable and undoubtedly necessary in some instances. Neon signs, however, are not considered to be in good taste.

3. Members may use signs designating the name of their building. The size of the lettering shall not exceed eight inches square for each letter. The physician's name shall not appear in this sign.

4. Members may use outside signs designating their names and, if desired, their specialty. The size of the letters shall not exceed four inches square for each letter.

5. Members may use inside signs designating their names and, if desired, their specialty. The size of the letters shall not exceed two inches square for each letter.

6. The letters "M. D." shall be used following the physician's name, rather than the title "Doctor" or its abbreviation, "Dr.," preceding the name.

7. Since it is impossible to make rules applicable to all situations, the Council of the Academy of Medicine of Cincinnati, or its duly appointed representatives, shall have the power to make the final decision regarding the acceptability of any sign and shall approve exceptions to the above recommendations.

SPECIAL NOTICES

1. Newspaper Notices. It has long been an acceptable practice in the Greater Cincinnati area for the physician to place in the newspaper professional cards or notices announcing the opening of an office, removal or change of office, association or disassociation with other physicians, resumption of practice after military or other leave of absence and "at home" after termination of a vacation. The committee recommends that this practice be continued and be limited by the following standards:

a. Notices shall be placed only in the daily and suburban newspapers. Notices shall not be placed in church and fraternal magazines, directories, and other publications.

b. The standard size of a notice for any one physician shall be one column by eight lines. The size of the type shall not exceed 18 points (approximately one-quarter inch in height—72 points to an inch).

c. The notice of a physician resuming practice after military or other leave of absence, the notice of a new physician opening an office or forming a new association may state the name, specialty, location, telephone number, and office hours. It shall run for not more than seven days.

d. The notice of a physician announcing the removal or change of an office, the association or disassociation with other physicians, or "at home" after vacation, shall state the physician's name, location and telephone number. The committee feels that it is not necessary for an established physician to

Thank you doctor for telling mother about...



The Best Tasting Aspirin you can prescribe

The Flavor Remains Stable down to the last tablet

15¢ Bottle of 24 tablets (2½ grs. each)

We will be pleased to send samples on request

THE BAYER COMPANY DIVISION of Sterling Drug Inc., 1450 Broadway, New York 18, N. Y.

state the specialty or office hours. It shall run for not more than two days.

2. Other Notices:

a. Cards announcing the opening of a new office, removal or change of an office, association or disassociation with other physicians and resumption of practice after military or other leave of absence may be sent through the mail to members of the profession, personal friends and patients.

Council adopted the recommendations made by the Public Relations Subcommittee on Medical Advertising. These rules became effective March 2, 1954.

Student A. M. A. Holds Its Largest Meeting

The Student American Medical Association held its best and largest annual meeting in May. Fifty seven delegates participated in the house of delegates sessions and the registrations for members and guests totaled nearly 1,000.

John Oates, Jr., sophomore delegate from the Bowman Gray School of Medicine, is the new national president. Other officers are: Dan Heffernan, junior, Wayne University, vice-president, and Don Overstreet, junior, Alabama, treasurer.

The newly elected president, John Oates, represented his association at the board of directors meeting of the National Intern Matching Plan, Inc., which met at the same time. He told the board that the house of delegates voted in favor of corporate membership. It is likely that the plan will approve the request. Final O. K. rests with the approving bodies of the various associations making up the plan.

Many spirited discussions featured the house of delegates sessions.

The S. A. M. A. house recommended that responsibility for non-service-connected medical care for veterans revert, through change in existing law, to the individual or, in case of indigency, to local or state governments.

Another resolution supported use of dogs in medical research.

Acting on a resolution asking a minimum intern pay scale of $100 per month, the students' reference committee on postgraduate training proposed that the standing committee on graduate training conduct a survey to determine "the opinions in the establishment of a minimum standard of payment per month above and beyond the services of room, board and laundry." The reference committee report was adopted. The survey will be completed before the 1955 S. A. M. A. convention, which will be held in Chicago, May 6, 7, 8.

Following two hours debate, the house by a close vote decided neither to favor nor disapprove a pending proposal for federal military medical scholarships.



THOROUGHBRED IN ITS FIELD

Audivox, successor to Western Electric Hearing Aid Division, brings the boon of better hearing to thousands.

These are the Audivox Hearing Aid Dealers who serve you in Ohio. Audivox dealers are chosen for their competence and their interest in your patients' hearing problems.

AKRON
Audiphone Company of Akron
807 Second National Bank Building
Tel: HEmlock 5101

BRYAN
D. C. Farnham, Acoustic Company
220 South Lynn

CAMBRIDGE
Fanley Audiphone Company
710 Taylor Avenue

CANTON
Audiphone Company of Canton
422-23 First National Building; Tel. 42510

CINCINNATI
Peeples Audiphone Company
527 Union Central Building; Tel. MAin 0207

CLEVELAND
Audiphone Company of Cleveland, Inc.
725 Rose Building; Tel. PRospect 1-6259

COLUMBUS
Fanley Audiphone Company
150 East State Street; Tel. ADams 4747

DAYTON
Audiphone Company of Dayton
502 Hulman Building
120 West 2nd Street; Tel: FUlton 3083

DELPHOS
Joseph J. Kloeppel Hearing Aid Service

MANSFIELD
The National Electric Company
80 North Walnut Street

PIQUA
Rachel Hauschildt
637 West Ash Street

PORTSMOUTH
Wursters Drug Company, Inc.
419 Chillicothe Street

TOLEDO
Audiphone Company of Toledo
936 Edison Building; Tel. GArfield 3301

WARREN
Griswold's Hearing Aid Center
144-150 South Park Avenue; Tel. 4-9222

YOUNGSTOWN
Hearing Aid Center
Strouss Hirshberg Company

HUNTINGTON, WEST VIRGINIA
Joseph Hague
405 West Virginia Building; Tel. 6688

PARKERSBURG, WEST VIRGINIA
Rawlings Opticians, Inc.
221 Seventh Street; Tel. 7-5461

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TRADE-MARK
SUCCESSOR TO
Western Electric
HEARING AID DIVISION



Audivox new all-transistor model 71 hearing aid

thoroughbred

Only a long and celebrated ancestry can produce a champion racing thoroughbred.

Only **audivox** in the hearing aid field can trace an ancestry that includes both Western Electric and Bell Telephone Laboratories. **audivox** lineage springs from the pioneer experiments of Dr. Alexander Graham Bell, which were furthered by the development of the hearing aid at Bell Telephone Laboratories, and in turn, brought to fruition by Western Electric and **audivox** engineers.

Distinctly a thoroughbred in its field, **audivox** , successor to Western Electric Hearing Aid Division, brings the boon of better hearing, and its enrichment of living, to thousands. With the magical modern transistor, with scientific hearing measurement and scientific instrument-fitting, serviced by a nationwide network of professionally-skilled dealers, **audivox** moves forward today in a proud tradition.

TO THE DOCTOR: Send your patient with a hearing problem to a career Audivox and Micronic dealer, chosen for his interest, integrity and ability. There is such an Audivox dealer in every major city from coast to coast.



Alexander Graham Bell

audivox

Successor to *Western Electric* Hearing Aid Division

123 Worcester St., Boston, Mass.

The Thoroughbred Hearing Aid

In Memoriam . . .

Roscoe Porter Albaugh, M. D., Bay Village; Ohio State University College of Medicine, 1914; aged 65; died May 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Albaugh had been a practicing physician in the Greater Cleveland area for 35 years. In addition to his private practice, he was chief surgeon for the Republic Steel Corporation. He was a member of the Westwood Country Club and a former member of the Cleveland Athletic Club. Surviving are his widow and a sister.

Earl Zartman Alspach, M. D., Akron; Starling Medical College, Columbus, 1903; aged 73; died May 22; former member of the Ohio State Medical Association, last in 1932. Dr. Alspach had been a practicing physician in the Kenmore area of Akron for 50 years. A veteran of World War I, he was a member of the American Legion. A sister survives.

Ralph Raymond Barrett, M. D., Huntington Park, Calif.; Eclectic Medical College, Cincinnati. 1902; aged 79; died May 27; former member of the Ohio State Medical Association, last in 1922. Dr. Barrett practiced for about 20 years in Mansfield before he moved to California many years ago. He is survived by his widow, three daughters and a sister.

J. H. Beatty, M. D., Tonkawa, Okla.; University of Wooster, Medical Department, Cleveland, 1903; aged 78; died April 28. Dr. Beatty practiced for 15 years in Canton before he moved to Oklahoma where he continued in practice until his retirement two years ago. He is survived by a son and two sisters.

Denver S. Burns, M. D., Bryan; Ohio Medical University, Columbus, 1904; aged 74; died May 7; member of the Ohio State Medical Association through 1940; president of the Williams County Medical Society in 1922 and in 1929; Dr. Burns moved to Bryan in 1908 after serving for a few years with the Columbus State School. During World War I, he served in the Army Medical Corps. Ill health forced his retirement in 1939. Dr. Burns was a member of several Masonic bodies, the Methodist Church and the American Legion. He also was a director of the Citizens Bank of Bryan. Surviving are his widow, and a son.

Arnold W. Ganzel, M. D.; Cincinnati; Eclectic Medical College, Cincinnati, 1919; aged 65; died April 29; member of the Ohio State Medical Association. Dr. Ganzel's practice included work on the attending staff of Bethesda Hospital for many years.

Edward Porter Gillette, M. D., University of Michigan Medical School, 1922; aged 57; died May 2; member of the Ohio State Medical Association and member of the American Medical Association; Fellow of the American College of Surgeons. Dr. Gillette served all of his professional career in Toledo where he was associated in practice with his three brothers and formerly with his father, the late Dr. William J. Gillette. He was formerly chief of staff at St. Luke's Hospital and was a past-president of the Northern Tri-State Medical Association. Other affiliations included membership in the Toledo Club and several Masonic bodies, among them the Shrine. Surviving are his widow; a son, Dr. Edward P. Gillette, Jr., of Indianapolis; two daughters; his mother; and three brothers, Drs. E. Benjamin, Norris and Robert Gillette.

Frank D. Halleck, M. D., Bowling Green; Ohio Medical University, Columbus, 1898; aged 81; died May 14; member of the Ohio State Medical Association and the American Medical Association; past-president and former secretary of the Wood County Medical Society; also active on a number of county society committees. Dr. Halleck began his practice in Portage, but moved to Bowling Green in 1901. In addition to his medical practice, he was active in a number of community groups including the Kiwanis Club, the local Chamber of Commerce, the Baptist Church and the Masonic Lodge. Survivors include a son and a sister.

Chester E. James, M. D., Massillon; University of Wooster, Medical Department, Cleveland, 1903; aged 86; died April 22; former member of the Ohio State Medical Association. Dr. James practiced for many years in the Garrettsville-Welshfield-Troy area. He was a 32nd Degree Mason. Two daughters survive.

Arthur K. Lawrence, M. D., Columbus; Ohio Medical University, Columbus, 1907; aged 78; died May 19; member of the Ohio State Medical Association through 1948. Dr. Lawrence practiced for approximately 30 years in Columbus. He was a 33rd Degree Mason and an active worker in the Elks Lodge. Survivors include his widow and two sons.

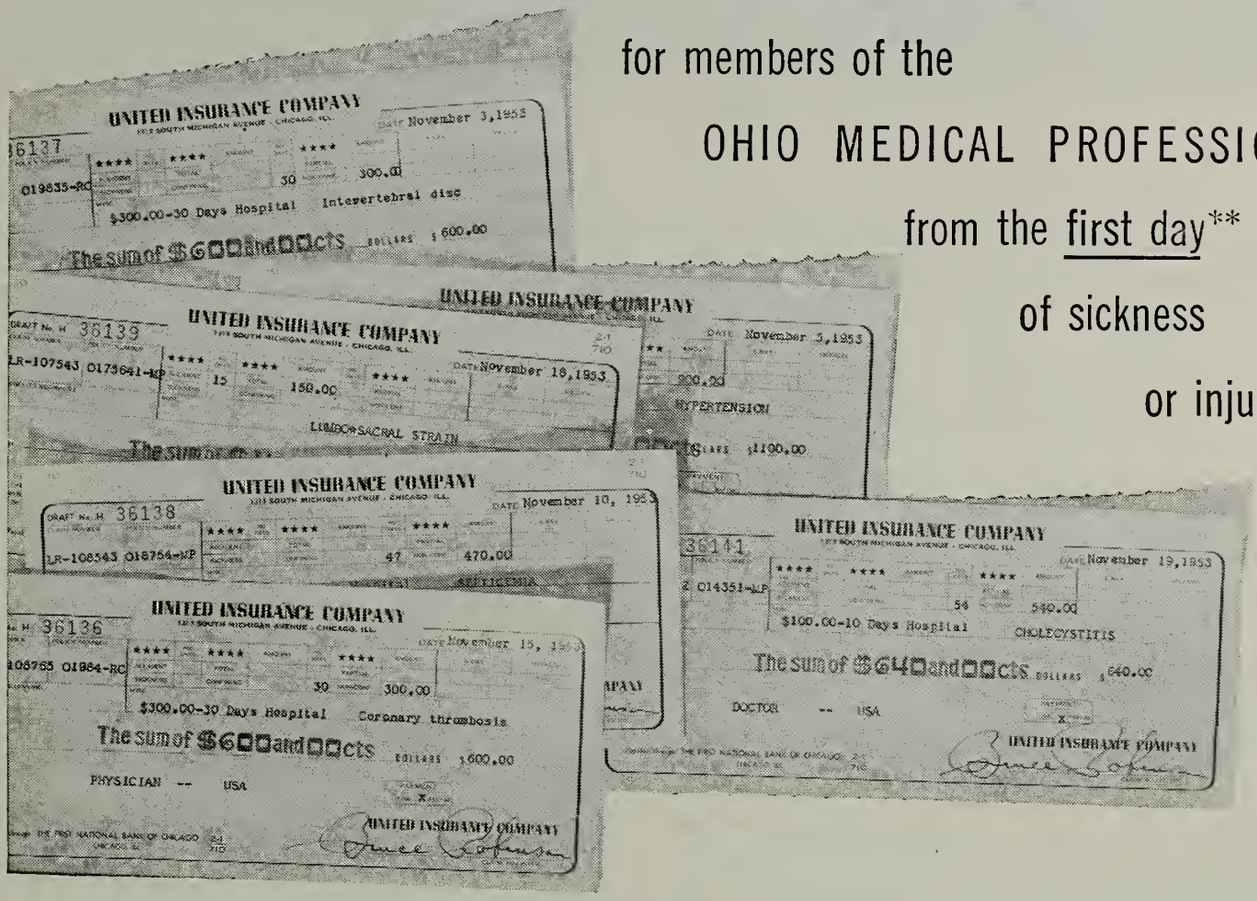
Albert Verne Lerch, M. D., Pleasantville; Starling Medical College, Columbus, 1892; aged 85; died May 10; member of the Ohio State Medical Association; past-president of the Fairfield County Medical Society. Dr. Lerch opened his practice in Pleasantville upon completion of his medical education in 1892. An ardent supporter of local educational facilities, he was for 10 years president of the Board of Education. He was also active on the district Board of Health. For 25 years Dr. Lerch was surgeon for the New York Central System in that area. Affiliations included mem-

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for members of the

OHIO MEDICAL PROFESSION

from the first day** of sickness or injury



now! Not for only 26 weeks—Not for only 52 weeks
but even for your entire lifetime
House Confinement is not required at any time
Accidental loss of hands, feet or eyesight pays
monthly benefits—not just lump sum

tax free dollars Disability income is not taxable. For example: $3600.00 a year from our policy is equivalent to about $5000.00 regular income

extra benefits Double monthly benefits when you are hospitalized for as long as three months.
Unusually large accidental death benefits
Double benefits for specified travel accidents

plus important features Waiver of Premium Provision
Commercial Air Travel Passenger Coverage
No automatic termination age

**In the event of total disability and total loss of time*

***Benefit payments start from first day of medical attention*

Mail coupon TODAY while you are still healthy! ▶

UNITED INSURANCE COMPANY, Lifetime Dept.
Carnegie Hall, Cleveland 15, Ohio

I would like to know more about your lifetime protection.

NAME_____ AGE_____

ADDRESS_____

or clip to your letterhead

as advertised in The Journal of the American Medical Association

berships in the Methodist Church and the Masonic Lodge. A grandson survives.

Robert M. McMichael, M. D., Muncie, Ind.; Western Reserve University School of Medicine, 1931; aged 48; died May 19. After completing his medical education and internship in Cleveland, Dr. McMichael moved to Muncie where he had been practicing since. His parents survive.

William C. Miller, M. D., Belmore; Eclectic Medical College, Cincinnati, 1902; aged 79; died May 2. A native of Putnam County, Dr. Miller served all of his professional career there. He was a former coroner of the county, having served 10 years in that capacity. Another local interest was the local school board which he served as clerk for a number of years. He was superintendent of the local church school and led a men's class for many years in the Evangelical United Brethren Church. Survivors include his widow; a son, Dr. Harry J. Miller, of McComb: and a daughter.

Vincent G. Peiffer, M. D., formerly of Avon Lake; Ohio State University College of Medicine, 1942; aged 38; died May 22 in a traffic accident while motoring in Wisconsin; member of the Ohio State Medical Association through 1952. After serving with the Coast Guard during World War II, Dr. Peiffer practiced for several years at Avon Lake. He moved two years ago to Chicago where he was doing residency work. Surviving are his widow, a daughter, his parents, three brothers and six sisters. His son died with him in the accident.

Charles E. Schilling, M. D., Houston, Texas; Western Reserve University, 1892; aged 86; died June 2; member of the Ohio State Medical Association through 1943. Dr. Schilling practiced in Canton from 1898 until 1920 when he moved to Columbus where he was medical advisor to the Ohio State Life Insurance Company. In 1948 he moved to Florida and later retired and moved to Texas. He was a member of the Masonic Lodge. Surviving are a daughter and a sister.

Peter J. Simon, M. D., Cleveland; Eclectic Medical College, Cincinnati, 1938; aged 43; died June 7; member of the Ohio State Medical Association and of the American Medical Association. Dr. Simon practiced in the west side area of Cleveland. He was fleet surgeon for the Lakeside Yacht Club and belonged to the U. S. Power Squadron and the Fraternal Order of Police. He also was a member of several Masonic bodies and the Congregational Church. Surviving are his widow and two sisters.

Frederick P. Swing, M. D., Ft. Lauderdale, Fla.; University of Cincinnati College of Medicine, 1934; aged 46; died May 2; former member of the Ohio State Medical Association and later a member of the Florida State Medical Association. Dr. Swing practiced in Cincinnati until 1944 when he moved to Florida. He was a member of the Kiwanis Club and the Elks Club. Survivors include his widow, two sons, his parents and a brother.

Cassius M. Treffinger, M. D., Eaton; Eclectic Medical College, Cincinnati, 1917; aged 63; died May 24; member of the Ohio State Medical Association; past-president, former secretary-treasurer and former delegate of the Preble County Medical Society; also active as chairman and member of numerous county society committees. A native of Preble County, Dr. Treffinger had served all of his professional career there. He had only recently been named county coroner, a post which he also held formerly. Dr. Treffinger was a member of the Masonic Lodge and the American Legion. Surviving are his widow, two sons and two sisters.

Edward Newport Walker, M. D., Akron; College of Physicians and Surgeons, Kansas City, 1899; aged 82; died May 22; member of the Ohio State Medical Association through 1950. Dr. Walker practiced in Missouri before moving to the Ellet district of Akron in 1917. He was a former president of the local board of education and was active for some time on the Summit County Board of Health; also a member of the Presbyterian Church. Surviving are a daughter, a son, two brothers and a sister.



SoapMaster dispensers in your washrooms

afford the finest possible handwashings at the lowest possible cost—and in a completely sanitary manner. SoapMasters are fully guaranteed.

Choice of 3 types superb quality soap

accepted by AMA, available for use in the SoapMaster dispenser to meet all requirements.

ACCEPTED COMMITTEE ON COSMETICS AMERICAN MEDICAL ASSOCIATION

For name of local distributor write

VOORHIS-TIEBOUT CO., INC. Red Hook 3, New York

NOT ARTHRITIS BUT ARTHRALGIA...

If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.[1] It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.[2] In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

"Premarin" is an excellent preparation for the replacement of body estrogen. In "Premarin" all components of the complete equine estrogen-complex are meticulously preserved in their natural form. "Premarin" produces not only prompt symptomatic relief but a distinctive "sense of well-being" which is most gratifying to the patient.

1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

"PREMARIN"®

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Estrogenic substances (water-soluble) also known as conjugated estrogens (equine)
Available in tablet and liquid form

has no odor . . . imparts no odor

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5410

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D., MIDDLETOWN)

BUTLER

Dr. F. L. Shively, Jr., Dayton, president-elect of the Montgomery County Medical Society, was guest speaker at a dinner meeting of the Butler County Medical Society on June 2 in Middletown. He spoke on the role of the individual and the medical society in the public relations program. The speaker was presented by Dr. Charles Hauser, Hamilton, chairman of the Butler Society's public relations committee.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

MONTGOMERY

Dr. Frank L. Shively, Jr., Dayton, was named president-elect of the Montgomery County Medical Society at the May 26 meeting. Other officers elected are Dr. Herbert R. Cammerer, vice-president; Dr. Mason S. Jones, secretary; and Dr. Joseph M. Wilson, treasurer. All officers take office in January 1955. Current president is Dr. Richard C. Miller. Dr. T. L. Light will succeed him in January.

The medical call service operated under direction of the Montgomery County Medical Society announced the following comparative figures on the growth of its services: Total incoming calls, January-May 1952, 29,761; total incoming calls, January-May 1953, 57,697; total incoming calls, January-May 1954, 88,037. Highest volume for one day was 937 calls on March 10, 1954.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

LOGAN

Dr. Lee E. Traul, of Bellefontaine, was honored by the Logan County Medical Society upon completion of 50 years of service in the profession. He was presented the 50-Year Pin of the Ohio State Medical Association by Dr. J. R. Jarvis, Van Wert, Councilor of the Third District.

Dr. Traul began his practice in Middleburg in 1904 and still maintains an office there although his main office has been in Bellefontaine for many years. He has been Logan County health commissioner for 20 years and commissioner of Logan and Shelby Counties for 10 years.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The last of the color television series was held at the Academy Building of the Academy of Medicine of Toledo and Lucas County on June 2. The title was "Research."

The general meeting of the Academy was held on June 4, when semi-annual reports of all standing committees were received. Entertainment was a playlet by members of the Woman's Auxiliary.

The series of Inter-Hospital Postgraduate Lectures is announced weekly beginning July 6 and running through August 24. The series is being presented by the Medical Advancement Trust of the Maumee Valley Hospital and the Northwestern Ohio Heart Association. Speaker for the lectures will be Dr. Gordon B. Myers, professor of medicine, Wayne University.

OTTAWA

The Ottawa County Medical Society celebrated the fifteenth year of its founding with a dinner on May 26 at the Catawba Cliffs Beach Club.

Fourteen members of the society with Dr. Wilson P. Shortridge, presiding as president of the group, were present with their wives.

Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District, brought greetings to the group. Present for the occasion were Dr. and Mrs. Carl Yeisley, Bakersfield, Calif.; Dr. and Mrs. A. A. Brindley, Toledo; Mrs. L. L. Belt, San Diego, Calif.; and Dr. and Mrs. A. S. Mack, Mt. Vernon.

Reminiscences of their membership in the Society were given by Dr. Yeisley and Dr. Brindley, both former presidents. Mrs. Belt spoke of her experiences as a school health nurse in the county.

Mr. Charles S. Nelson, Columbus, Executive Secretary of the Ohio State Medical Association, brought greetings of the State Association and presented excerpts from *The Ohio State Medical Journal* issue which announced chartering of the Ottawa County Medical Society in 1904, showing the wide change in many types of medical treatment today as compared to that year.

An informal reception at the home of Dr. and Mrs. C. R. Wood preceded the dinner.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

CUYAHOGA

The Distinguished Service Award of the Academy of Medicine of Cleveland was presented on May 21 to Dr. Samuel Webster, of Parma, who has practiced medicine in the Greater Cleveland area for 58 years.

Dr. Webster received his medical degree from Western Reserve University in 1896 and began practice in South Euclid. Dr. Harold Feil made

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the presentation to Dr. Webster. Dr. John H. Budd, president of the Academy, gave his annual report, stressing the broadening scope of medical society activities.

Guest speaker was N. R. Howard, editor of the *Cleveland News* whose topic was "The Happy Life of a Doctor."

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

A dinner dance for members of the Mahoning County Medical Society and the Auxiliary was held on May 8 at the Youngstown Country Club.

TRUMBULL

The Trumbull County Medical Society and Auxiliary met late in May for a dinner meeting at Warren. The speaker was Dr. Allen Schroeder, director of the Law Medical Center at Western Reserve Law School, who talked on "Law, Medicine and the Future."

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society held its monthly meeting at the Belmont Hills Country Club on May 20. Dr. Albert E. Kuhl, Dayton, presented a scientific discussion on the subject, "Diagnosis of Heart Disease and What May Be Expected from an Electrocardiogram."

Honor guest and after-dinner speaker was Dr. Merril D. Prugh, Dayton, President of the Ohio State Medical Association. He discussed the place of medicine in modern affairs and its obligations.

The meeting was combined with an outing at the Belmont Hills Country Club, at which members of the Woman's Auxiliary participated.

TUSCARAWAS

Twenty members and two guests were present at the meeting of Tuscarawas County Medical Society on May 12 at Union Hospital Auditorium. The guests were Miss Jean James of the Central Ohio Heart Association, and Dr. Hugh B. Hull, Ohio State University, speaker of the afternoon.

An interesting and instructive clinic on the "Auscultation of the Abnormal Heart Sounds" was held. Dr. Hull augmented his presentation by the use of a 5-inch oscilloscope, which demonstrated heart sounds on its screen, combined with 25 sets of stethophones through which all members present could hear the various heart sounds demonstrated.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The Scioto County Medical Society met at the Portsmouth General Hospital Nurses' Home on June 21. Dr. Thomas McMahon, medical director of the Portsmouth Receiving Hospital, informed members about facilities at the new hospital.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Members and guests of the Columbus Academy of Medicine participated in an outdoor recreation period on the University Golf Course on May 19, climaxed by an ox roast in the evening.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

MEDINA

Guest speaker at the June meeting of the Medina County Medical Society was Dr. H. T. Pease, Wadsworth, Councilor of the Eleventh District, who discussed phases of public relations.

RICHLAND

Approximately 50 members of the Richland County Medical Society met at the Westbrook Country Club in Mansfield, on May 20.

Following dinner and a business meeting, a very fine discussion of "Diseases of the Adolescent Hip" was presented by Dr. Clarence H. Heyman and Dr. Charles H. Herndon, of the Orthopedic Department at Western Reserve University School of Medicine.—P. O. Staker, M. D., Secretary-Treasurer.

Proctology Contest

The International Academy of Proctology has announced its annual Cash Prize and Certificate of Merit Award Contest for 1954-1955. The award is made on the basis of the best unpublished contribution on proctology or allied subjects. Additional information may be obtained from the Academy at 43-55 Kissena Blvd., Flushing, N. Y.

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1. Rev. Gastroenterology 20:744 (Oct.) 1953; abstract in J. A. M. A., 153:1580 (Dec. 26) 1953.

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President-Elect—Mrs. Karl Ritter, 1420 Shawnee Rd., Lima, Ohio

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ALLEN

"Ramblings of a Juvenile Judge" was the topic of an interesting talk by Judge Joseph B. Quatman, May 27, at a guest meeting held by the Auxiliary to the Lima and Allen County Academy of Medicine, in the home of Mrs. R. E. Bushong. Using the environment of a child as the basis for his talk, Judge Quatman emphasized the role played by the family, church, school and court in the development of the child.

Preceding the introduction of the speaker, Mrs. C. H. Zinmeister, Auxiliary president, conducted a business session. Mrs. Martin M. Sondheimer gave a report of the state meeting held recently in Columbus.

Hostess committee for the guest meeting included Mrs. A. M. Barone, Mrs. R. G. Hendershot, Mrs. Charles L. Blumstein and Mrs. Bushong.

BUTLER

The garden at the home of Mrs. Calvin Skinner on Central Ave was the scene recently of the final meeting of the season of the Woman's Auxiliary to the Butler County Medical Society.

Mrs. Rose A. Hill conducted installation rites for the organization's new officers. They are: Mrs. Gregory Gressel, president; Mrs. Carl Seyrer, vice-president; Mrs. Calvin Skinner, president-elect; Mrs. John Stewart, corresponding secretary; Mrs. Howard Hunter, recording secretary; Mrs. Arnold Gross, treasurer; and Mrs. M. F. Vereker, director.

The meeting was arranged by a committee composed of Mrs. W. H. Henry, Mrs. D. M. Blizzard, Mrs. Walter Roehll, Mrs. Arnold Leeds, Mrs. McCall Morris and Mrs. C. T. Atkinson.

CUYAHOGA

Mrs. Henry J. John, prominent in civic and church groups, is the new president of the Woman's Auxiliary to the Cuyahoga County Academy of Medicine. Mrs. Christopher A. Colombi is president-elect; Mrs. J. L. Bilton, vice-president; Mrs. Spencer Braden, recording secretary; Mrs. Allen E. Walker, corresponding secretary; Mrs. V. T. Kaval, treasurer; and Mrs. C. W. Munz, assistant treasurer.

The meeting was held in the Higbee Lounge with Mr. Paul B. Davis as guest speaker.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society met for luncheon at Hotel Lancaster on May 10. Mrs. Fred Spangler, president, welcomed Mrs. Victor Kistler into the Auxiliary as a new member.

An informative report was given by Mrs. Stanley Sneeringer on the recent convention held in Columbus. She urged the members to continue their interest in nurse recruitment and also to take an active part in all community health problems.

Mrs. Frederick W. James, State Publicity Chairman, installed the officers for the new year. They are as follows: Mrs. Boice VanGundy, president; Mrs. Hubert Amstutz, president-elect; Mrs. C. R. Reed, vice-president; Mrs. J. L. Kraker, secretary; and Mrs. M. E. Nichols, treasurer.

FRANKLIN

The May meeting of the Woman's Auxiliary to the Columbus Academy of Medicine was held at Ilonka's Provincial House. Mrs. George O. Hoskins was in charge of arrangements. Freda Frazier, monologue actress, gave a dramatization of the book *Night of the Hunter*.

The Auxiliary's new officers were introduced at the luncheon. They are: Mrs. Henry Lacey, president; Mrs. A. L. Kefauver, president-elect; Mrs. Charles W. Mathews, vice-president; Mrs. Ollie Goodloe, recording secretary; Mrs. Arthur M. Call, corresponding secretary; and Mrs. Edwin M. Ellison, treasurer.

A new suction machine was given recently to the Alum Crest Hospital. So far this year the group has also donated $300 to the Council for Retarded Children, Inc., $300 to the American Medical Education Foundation, and is continuing three nurses on scholarships at local hospitals, as well as starting a fourth nurse.

HAMILTON

The Woman's Auxiliary to the Hamilton County Medical Society met April 20 at the Kenwood Country Club. Mrs. Don M. Berning and Mrs. John G. Fleming were in charge of the meeting. During the brief business session, conducted by the president, Mrs. Robert H. Kotte, annual reports were read and new officers elected.

Mrs. Howard L. Stitt, composer and lecturer, spoke on "Music and Ancient Therapy."

A picnic at Oak Ridge, Mt. Airy Forest, was recently enjoyed by the Woman's Auxiliary to the Hamilton County Medical Society. At this time the new officers for the year were installed. Mrs. Robert M. Woolford will be president; Mrs. Earl

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C. VanHorn, vice-president; Mrs. Herbert J. Brinker, president-elect; Mrs. Franklin R. Geiger, treasurer, Mrs. Joseph J. Podesta, corresponding secretary; Mrs. I. C. Sharon, recording secretary; and Mrs. Gaston B. Hannah, director.

The group held a Hobby and Talent auction at Oak Ridge Lodge on May 18. Proceeds from this sale were added to the Auxiliary's philanthropic fund. Ceramic figures, vases, ash trays, bowls, jewelry, toys, and a loom woven rug were among the many useful and beautiful articles at the auction.

LICKING

Mrs. Edwin Lane was elected president of the Woman's Auxiliary to the Licking County Medical Society during the April meeting at Hotel Warden. The other officers chosen were Mrs. Ralph Pickett, president-elect; Mrs. John Fleck Miller, vice-president; Mrs. Carl Frye, secretary; and Mrs. George Gressle, treasurer.

During the business meeting conducted by Mrs. Carl Petersilge, it was announced that Mrs. George Gressle was installed as Director of the Eighth District during the state convention.

The May 25 meeting of the Auxiliary was held at Hotel Warden. Mrs. Paul Grove reported on the work shop for Future Nurses Clubs held in Cleveland May 15. She also described the tea held by the Granville Future Nurses' Club which is sponsored by the Auxiliary.

LOGAN

Members of the Woman's Auxiliary of the Logan County Medical Society enjoyed a covered dish luncheon for the last meeting of the current season. The affair was held in the home of Mrs. L. E. Traul in Middleburg.

The period of business featured installation of officers. They are: Mrs. C. H. Thompson, president; Mrs. Hobart Mikesell, president-elect; Mrs. Warren Mills, vice-president; Mrs. R. A. Firmin, recording secretary; Mrs. F. Flair Webster, corresponding secretary; and Mrs. Frederick Kaylor, treasurer.

An interesting report of the State convention was given by Mrs. Mills, who served on a panel discussion concerning the Auxiliary hand-book.

LUCAS

The Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County held its April meeting at the Academy Building. Mrs. John Gallagher and Mrs. W. Leroy Bryant served as lucheon chairmen.

Mrs. J. E. Minns reported on facilities available for heart patients in Lucas County. Other reports were given by Mrs. Frank Rawling, allergy; Mrs. David Frick, diabetes; and Mrs. Martin Lorenzen, geriatrics.

About 80 clubwomen met recently at the Toledo Woman's Club, to honor State Representative Opal Mundy, who will soon retire from public life. Mrs. Mundy is the only Lucas County woman to have served four terms in the State Legislature. She is the wife of Dr. Carll S. Mundy.

The Lucas County Auxiliary has been awarded first prize for outstanding achievement in programs and purpose in 1953 by the Woman's Auxiliary to the Ohio State Medical Association. The group received the award in competition with 60 auxiliaries in the State.

A guest meeting, in the form of a salad bridge party, was held recently by the Woman's Auxiliary. A spring fashion show, for which Auxiliary members modelled, was the program feature. Committee chairmen were: Mrs. J. B. Hirsch, Mrs. H. P. Shapiro; Mrs. O. H. Stone, Mrs. Fred Gipson, Mrs. Fred Douglass, Jr., and Mrs. Ned B. Hein.

MONTGOMERY

The Woman's Auxiliary to the Montgomery County Medical Society held its annual installation meeting at Highview Terrace in Bellbrook on May 11. Officers for the coming year are: Mrs. C. C. Payne, president; Mrs. M. E. Black, vice-president; Mrs. E. W. Smith, president-elect; Mrs. D. C. Caudill, recording secretary; Mrs. Norman Birckbeck, corresponding secretary; and Mrs. L. E. Rausch, treasurer.

An interesting talk on "Old Lace" was given by Mrs. John Graff. Hostesses for the meeting were Mrs. Robert Pumphrey, Mrs. J. A. Mendelsohn, Mrs. Sam Chudde, Mrs. R. C. Craig, Mrs. R. L. Haas, Mrs. B. C. Stuhlman and Mrs. Wm. Doherty.

ROSS

Dr. Alvin Howard, of the V. A. Hospital, was speaker at the Woman's Auxiliary to the Ross County Academy of Medicine, May 6 at Allyn's dining room. "Mental Health" was the speaker's subject. His talk dealt mostly with the history of the care of mental cases and he contrasted the excellent care the mentally ill receive today with the primitive methods first used in treating such patients.

The new officers were in charge of the meeting. They are: Mrs. G. Howard Wood, president; Mrs. Robert P. Geisler, vice-president; Mrs. Jack Berno, secretary; Mrs. Buel Ashmore, treasurer; and Mrs. Nicholas Holmes, Mrs. Wood, Mrs. Geisler and Mrs. Utra on the board of directors.

SANDUSKY

Members of the Auxiliary to Sandusky County Medical Society met April 20 in the home of Mrs. J. J. Gedert in Clyde with Mrs. E. J. Shanahan and Mrs. E. A. Baker assisting. During the business meeting, with Mrs. A. P. Newman presiding, the report of the nominating committee was accepted. The new officers are: Mrs. L. E. Drossell, Woodville, president; Mrs. Merritt Huber, Bettsville, vice-president; Mrs. Glenn

Walker, Woodville, secretary; and Mrs. Carl Wolf, Fremont, treasurer.

SHELBY

The sponsoring of a professional exhibit at the Shelby County Fair in August will be a project of the Auxiliary to the Shelby County Medical Society. These plans were made at the meeting held in the home of Mrs. E. P. Sparks on Port Jefferson Rd. where officers were named for the new year. Mrs. George Schroer will be the new president; Mrs. V. W. LeMaster, president-elect; Mrs. J. F. Conner, vice-president; Mrs. E. P. Sparks, secretary-treasurer.

STARK

The president's gavel of the Woman's Auxiliary to the Stark County Medical Society was handed over to Mrs. Herbert Jones, by the group's outgoing president, Mrs. A. Alvin Fisher. The meeting was held April 20 in the Alliance Woman's Club. Other officers for the new year are: Mrs. Francis C. Boyer, president-elect; Mrs. Harold J. Bowman, vice-president; Mrs. Howard J. Ickes, corresponding secretary; Mrs. James Kilduff, recording secretary; Mrs. Lee V. Schumaker, treasurer; and Mrs. Andrew W. McDonald, assistant treasurer.

The group voted to support the formation of "Future Nurses" clubs in the high schools. Money was donated to the Girl Scout Council.

Hostesses for the meeting were Mrs. W. D. Baker, Mrs. Wm. Elliott, Mrs. Geo. Ewing, Mrs. J. L. McClinoch, Mrs. Wm. McCrea, Mrs. E. M. Rowland and Mrs. Albert Wild.

Insurance Medical Research Fund Makes Grants for Heart Studies

The Life Insurance Medical Research Fund announced three institutional grants in Ohio for research on diseases of the heart and arteries—all of them at Western Reserve University School of Medicine. They are as follows:

For research by Dr. Gerhard A. Brecher on dynamic aspects of blood flow in physiological and pathological states, $8,250.

For research by Dr. A. B. Stavitsky on the basic mechanisms of antibody formation, $15,400.

For research by Dr. Harland G. Wood on the role of propanediol phosphate in metabolism, $19,800.

In addition, an individual predoctoral fellowship was awarded to Carl F. Rothe, M. Sc., Lima, for study with Dr. Leo. A. Sapirstein in the Ohio State University Graduate School. The stipend is between $2,000 and $2,400.

Throughout the nation the Life Insurance Medical Research Fund awarded grants and fellowships, totaling $878,000, bringing the total to $6,300,000 since the fund's organization in 1945.

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GYNECOLOGY—Office & Operative Gynecology, two weeks, Sept. 20. Vaginal Approach to Pelvic Surgery, one week, Sept. 13.

OBSTETRICS—General & Surgical Obstetrics, two weeks, Oct. 4.

MEDICINE—Two-Week Course Sept. 27. Electro-Cardiography & Heart Disease, two weeks, Oct. 11. Gastroenterology, two weeks, Oct. 25. Gastroscopy, one week, Sept. 13.

RADIOLOGY—Diagnostic Course, two weeks, Oct. 4. Clinical Uses of Radio Isotopes, two weeks, Oct. 4.

PEDIATRICS—Clinical Course. two weeks, by appointment. Congenital & Rheumatic Heart Disease in Infants & Children, one week, Oct. 11 and Oct. 18. Two weeks, Oct. 11.

UROLOGY—Two-Week Urology Course, Sept. 20. Ten-Day Practical Course in Cystoscopy every two weeks.

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11

Financing Hospital Care . . .

Special Commission, After Extensive Nation-Wide Study, Comes Up With Certain Recommendations for Present and Future Consideration

THE Commission on Financing of Hospital Care has announced its recommendations after a two-year nation-wide study, outlining a broad program for strengthening and extending voluntary prepayment and for keeping the costs of hospital services as low as possible consistent with good standards of care.

Gordon Gray, Chairman of the Commission and President of the University of North Carolina, stated the Commission formulated its recommendations, "to point the way for effective voluntary action, with minimal participation by government, to bring hospital care within financial reach of all people."

The Commission was composed of 34 national leaders from the health professions, industry, labor and other groups.

PLANS A "PUBLIC TRUST"

The Commission found that "the financial stability of the voluntary hospital system is dependent upon the degree to which voluntary prepayment enables both the general public and the hospitals to meet their common problem of financing hospital care."

Funds paid to the voluntary prepayment hospital plans, the Commission emphasized, are a "public trust" and "methods to assure economy and maximum effectiveness in their use are a joint obligation of hospitals, physicians, prepayment agencies and the general public."

Stress is given in the Commission's recommendations to development of measures for keeping prepayment costs as low as possible by eliminating unnecessary admissions to hospitals and by reducing unnecessary use of hospital beds prior to active treatment. The Commission suggested prompt discharge of patients after medical need no longer exists and the curtailment of unnecessary use of hospital beds for diagnostic and other services which can be given on an ambulatory basis as effective ways to reduce the cost to the public of prepaid hospital care.

MARGINAL INCOME PROBLEM

The Commission found that "provisions for financing hospital care for persons receiving public aid are, in most communities, insufficient to meet the costs of necessary hospital care; and, in many communities, provisions for financing hospital care for other marginal income groups are non-existent."

The Commission emphasized that, "If such groups as the aged, the unemployed, the disabled and low income, as well as public aid recipients, are to have access to needed hospital care, not only must additional funds be made available, but creative and imaginative approaches to financing and administration must be developed."

DETERMINING EFFECTIVENESS

The Commission recommendations include specific guides for states and communities in determining the effectiveness of voluntary prepayment arrangements in their areas. Many of its recommendations, the Commission believes, are applicable to particular community situations and can be used by state and local study groups.

Hospitals, physicians, prepayment agencies and other community groups, the Commission suggested, should establish state and local study and action committees to work together to promote maximum coverage of the population.

Pointing out that a substantial increase in unemployment would create serious financial problems for the patient and the hospital, the Commission recommended several methods for extending voluntary prepaid protection into periods of unemployment. It felt that this could be done by voluntary action with prepayment plan and employer cooperation.

The Commission proposed as one approach, however, the inclusion of voluntary prepayment costs in the unemployment compensation program.

AGED AND DISABLED

Aged retired persons and the permanently disabled, the Commission found, need more hospital care than other groups and are less able to pay for it. The Commission made two major recommendations on this subject. One encouraged employers to make provision for coverage of retired employees under voluntary prepayment plans as part of their pension programs. The other proposed "inclusion of a provision in the Federal Old Age and Survivors Insurance program for hospital protection for needy beneficiaries receiving monthly income maintenance benefits under this program."

The Commission recommended that the administration of such hospital benefits for OASI beneficiaries be the responsibility of state and local agencies and that protection be purchased from the voluntary prepayment plans or by payments directly to hospitals.

For the low income group, composed of persons

not on relief but unable to meet the cost of prepayment, the Commission proposed that governmental funds be used for experimentation in developing methods for improved financing of their hospital care through voluntary prepayment plans. Such funds should be administered, according to the Commission, by local agencies. The Commission observed that, to the extent low income families could be helped to budget for their hospital care through prepayment, dependency on local relief funds would be reduced.

INDIGENT

For the groups now receiving public relief, the Commission proposed federal grants to the states and localities for a limited period of time to encourage assumption of state and local responsibility. The Commission emphasized its belief that these groups can be brought under voluntary prepayment plans.

LABOR LEADERS TAKE EXCEPTION

Exceptions to certain parts of the Commission's recommendations were taken by Commission members Stanley H. Ruttenberg, CIO, and Boris Shishkin, AFL. Mr. Ruttenberg stated that the Commission's findings have two major weaknesses which "arise from the failure of the Commission to consider and recommend a comprehensive system of social insurance covering the costs of hospital care."

Mr. Ruttenberg said he believed that under the Commission's recommendations, "costs of belonging to voluntary prepayment plans would continue to be too high for a large segment of the population." He stated that this "results from an outstanding characteristic of the voluntary approach, namely, that members are charged the same amount regardless of differences in earnings."

Mr. Shishkin stated that "no reference is made to the possibility of placing health insurance coverage upon a comprehensive national base," and that "unwarranted stress is placed on confining the responsibility for remedies to the local community."

SPREAD OF RISK

The Commission recommended the broadest possible pooling of risks and costs on a community-wide basis to maintain as nearly uniform rates as possible in order to achieve maximum population coverage including protection for those groups often not covered.

It also recommended that state and local groups, established to determine the effectiveness of community voluntary prepayment arrangements, develop and support methods for coverage of the self-employed, farm families, individuals not in employed groups as well as all classes of dependents of persons presently covered.

It was also urged that the area-wide study groups determine the prevailing benefit provisions available to persons in the community. The public should be informed of the basic benefit provisions which are required for adequate protection, states one of the Commission recommendations.

SPECIAL LOCAL ATTENTION

In their recommendations to the public the Commission urged that state and local groups direct attention to:

1. Reduction in the multiplicity of benefit patterns;

2. Improved benefits to obviate the necessity for purchasing duplicate hospitalization protection;

3. Descriptions of benefit provisions which use non-technical language;

4. Elimination of unnecessary and trivial special benefits which tend to obscure the real nature of the contract and fail to indicate the serious deficiencies and limitations of the essential benefit provisions.

INFLUENCE OF INFLATION, ETC.

The Commission reported that inflation, population growth, and increased number of admissions were important reasons for increases in total hospital operating expenditures.

If the value of the dollar had remained unchanged from 1935 to 1952, the increase in total expenditures of all non-federal general hospitals would have been only 199 per cent.

If population had remained the same, the increase in total expenditures, after adjustment for inflation, would have been 148 per cent. Although hospital expenditures increased 199 per cent after adjustment for inflation, the concurrent increase in the total number of admissions means that costs per admission, after adjustment for inflation, rose only 20 per cent.

DANGER IN "OVER-BUILDING"

The recommendations of the Commission pointed out that many communities need more hospital beds but cautioned communities against over-building hospital facilities. Urging effective integration of services among community hospitals to avoid duplication, the Commission suggested that "before making capital expenditures for construction and equipment the hospital should carefully determine the needs of the community and its ability to finance the maintenance costs. Over-building with attendant failure to make full use of bed capacity and diagnostic and therapeutic facilities should be avoided."

The Commission stated that "methods which encourage early out-patient treatment may remove a later need for in-patient care" and that "prepaid benefit provisions for out-patient services as well as in-patient services will reduce the

present demand for unnecessary in-patient care." The need for increased numbers of trained hospital administrative personnel was also stressed.

USE OF SPECIAL HOSPITALS

"As a means of reducing unnecessary and prolonged use of hospital beds," the Commission recommended that "hospital trustees, administrators and medical staffs join in efforts to promote early referral of patients to special facilities for the care of chronic illness, convalescence, rehabilitation or to home care programs."

These special programs for long term care should be established by general and special hospitals or by other community groups and integrated with hospitals, according to the Commission. Hospitals should also cooperate in joint purchasing, training of interns and nurses, recruitment of personnel and efforts to obtain adequate community arrangements for financing care for public assistance groups.

Funds for the Commission's study program were made available by grants from the Blue Cross Commission, Health Information Foundation, John Hancock Mutual Life Insurance Company, W. K. Kellogg Foundation, Michigan Medical Service, Milbank Memorial Fund, National Foundation for Infantile Paralysis and the Rockefeller Foundation.

The Commission studies are being prepared for publication this spring and early summer. The reports will be in three volumes. Offices of the Commission are located at 50 East Oak Street, Chicago, Illinois.

Postgraduate Otolaryngology at University of Illinois

The Department of Otolaryngology, University of Illinois College of Medicine, announces its basic science course in otolaryngology offered by its affiliated hospitals. This combined postgraduate course and residency will begin its 1954-55 session on July 1, 1954. Other openings occur throughout the year. Residencies are available at either the Research and Educational Hospital or the Illinois Eye and Ear Infirmary, or a continuation of the training program may be arranged for the Veterans Administration Hospital at Hines.

Application forms or information are available on request to the Department of Otolaryngology. University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12.

Film on Alcoholism

Case studies of three types of alcoholics tracing the development of the disorder from origin are incorporated in a motion picture film which recently was added to the A. M. A.'s Motion Picture Library.

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Do You Know? . . .

Dr. E. J. Gordon, retired from his faculty post as clinical professor in the Department of Medicine, Ohio State University College of Medicine, after 44 years with the university.

* * *

Hart F. Page, assistant director of public relations, Ohio State Medical Association, is serving on the advisory committee for the 1955 convention of the Mid-West Association for Health, Physical Education and Recreation, an organization composed of educators, physicians and others. The Association will meet in Columbus March 30, 1955, for its 41st annual meeting.

* * *

Dr. Irvine H. Page, Cleveland, was honored at a testimonial dinner at the Union Club in Cleveland after being named president-elect of the American Heart Association.

* * *

The Third International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians, will be held in Barcelona, Spain, October 4-8. Additional information may be obtained from the American College of Chest Physicians, 112 E. Chestnut St., Chicago 11, Ill.

* * *

Dr. Albert C. Esposito, of Huntington, W. Va., formerly instructor in the Department of Ophthalmology at Ohio State University College of Medicine, was speaker before the Norvell Carter Medical Society in May, when he presented a paper with kodochrome illustrations of the cases on "Retrolental Fibroplasia."

* * *

Dr. Ernest D. Davis, Hamilton, was elected governor of District 231 of Rotary International at the Club's worldwide convention in Seattle, Wash. He will coordinate the service activities of 33 Rotary Clubs in one of four Ohio districts.

* * *

Dr. Edward J. McCormick, outgoing President of the American Medical Association, recently became the first recipient of the Catholic Action award of the Guild of St. Luke, composed of Catholic doctors of the Boston archdiocese. The guild has been organized for the better understanding of moral-medical problems.

* * *

The recently established Law-Medicine Center of Western Reserve University is undertaking a study of homicide in the Greater Cleveland area with consideration of cause, detection, solution, punishment, prevention and the like.

International Surgeons To Meet In Chicago, September 7-10

The Nineteenth Annual Congress of the United States and Canadian Sections of the International College of Surgeons will be held in Chicago, with headquarters at the Palmer House, September 7 through 10, with advance registration, business meetings, and a meeting of the Woman's Auxiliary on Labor Day, September 6.

Among Ohioans who are taking part in preparation of the program is Dr. Kenneth H. Abbott, Columbus, secretary of the Section on Neurosurgery.

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Eisenhower Recommends that ILO Convention Not Be Approved

The Eisenhower administration has forwarded to Congress, **with a recommendation that it not be ratified,** the International Labor Organization's convention on minimum standards of social security.

The convention, adopted by ILO in 1952, has caused concern in medical and other groups. It covers nine fields: medical care, sickness benefits, unemployment benefits, old age benefits, employment injury benefits, family benefits, maternity benefits, invalidity benefits and survivor benefits. A government is considered to have ratified the convention if it promises to meet the requirements in three of the nine fields.

The medical care section stipulates that a country may qualify as ratifying if it agrees to provide one of the following: (a) A system of compulsory health insurance; (b) private, voluntary health insurance "administered by public authorities under established regulations" set by law, or (c) private, voluntary health insurance administered by insurance companies but under government "supervision." Half the population would have to be covered.

In transmitting the convention to Congress, the President said it "is . . . regarded as not suitable for ratification but rather for referral to the appropriate federal and state authorities for their consideration."

An accompanying summary of comment from all affected federal departments and agencies pointed out that federal laws already are in accord with two of the points, old age insurance and survivors insurance. On the other points, the agencies came to the same conclusion as the President, namely that these issues are within the jurisdiction of state governments, and "that therefore the convention is not appropriate for ratification" by Congress.

The summary also noted that while signatories to the convention agreed to bring it before their respective legislative bodies, "it is entirely within the discretion of the competent authority of each country to determine whether any legislation is to be enacted."

The brief was concurred in by Commerce, Interior, Justice, Labor, Navy, and Health, Education, and Welfare Departments, and by the Civil Service Commission.

The University of Cincinnati College of Medicine has received a $12,000 U. S. Public Health grant for a unique study of emotional and personal problems and their relationship to illnesses of surgical patients. Dr. William A. Altemeier, will head the surgical study team and Dr. Maurice Levine the psychiatric team.

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Dr. Schriver Resigns Faculty Post After 41 Years Service

Retiring at his own request after 41 years of service in the University of Cincinnati College of Medicine, Department of Surgery, Dr. L. Howard Schriver was honored May 28, at an informal testimonial dinner at the Miami Boat Club by close friends and associates. Included were members of the University's department of surgery, former students now practicing in the profession, and professional associates in the community.

A 1910 graduate of the college, Dr. Schriver first joined the University of Cincinnati faculty in June 1913.

His retirement was prompted by the demands of his practice and the fact that he is now president of the National Blue Shield Commission. This commission office takes a great deal of his time for organization work and travel.

Dr. William A. Altemeier, director of the department of surgery in the U. C. college, acting on behalf of members of the department, presented Dr. Schriver with a set of engraved, solid-gold cuff links.

Dr. Altemeier noted that Dr. Schriver's request for retirement "is being accepted with great reluctance and with gratitude for his excellent past services to the University and to the department of surgery." Dr. Schriver is a former president of the Ohio State Medical Association.

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GENERAL PRACTITIONER, 30, family, Michigan license, 3 years civilian practice, 2 years Army, desires assistantship or salaried position with clinical group, or university health service. Winslow G. Fox, Capt., M. C., 136 Carrol Dr., Walker Village, Killeen, Texas.

INTERNIST, Certified, 38, wishes information regarding association with internist, solo practice or part-time position with opportunity for private practice. Box 783 c/o Ohio State Medical Journal.

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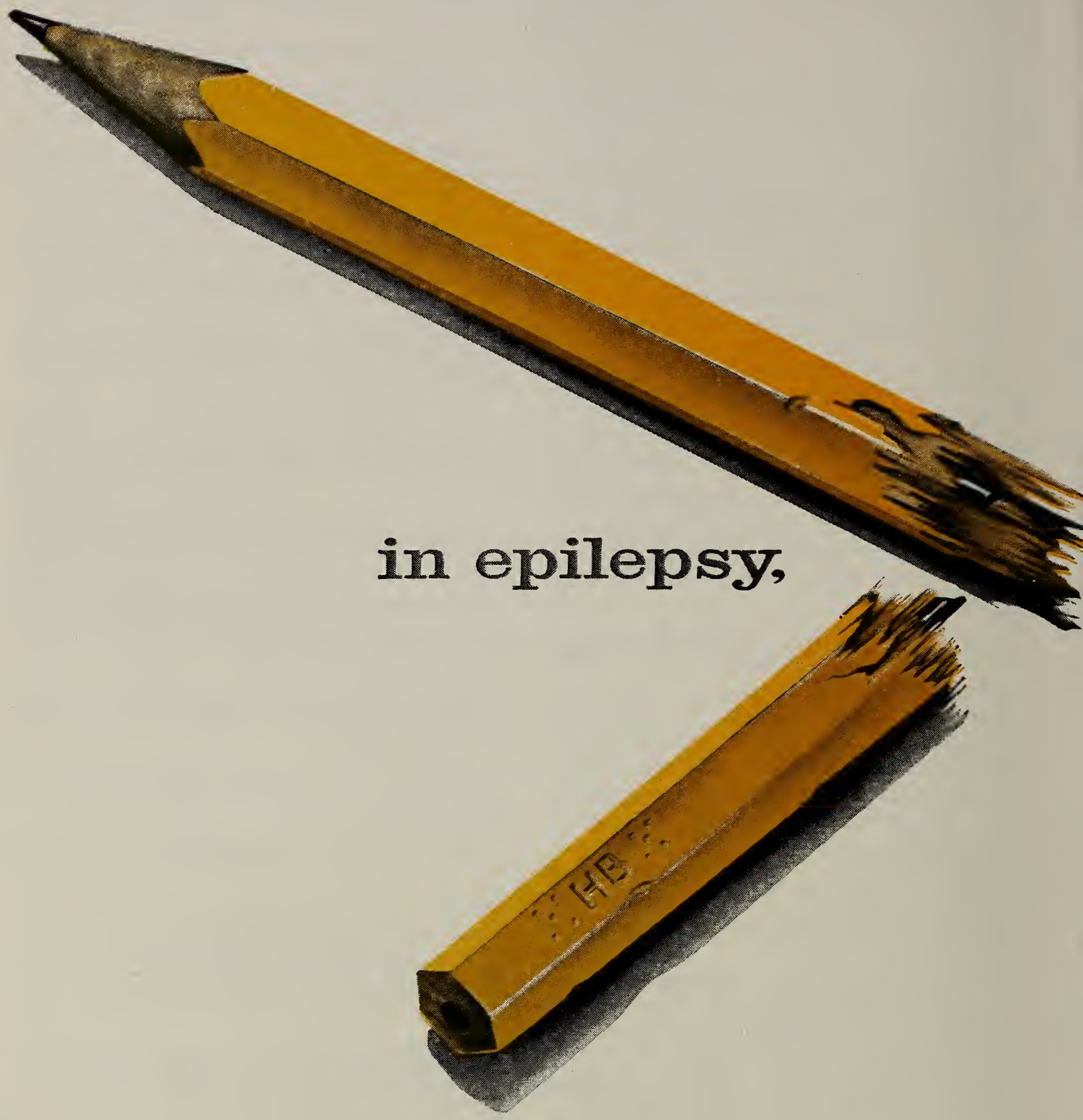
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1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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The Physician's Bookshelf

JONATHAN FORMAN, M. D.

Psychological Reflections: An Anthology from the Writings of C. G. Jung, Selected by Jolande Jacobi. Bollingen Series XXXI. ($4.50 *Pantheon Books, Inc., New York 14, N. Y.).* In these days when our industrial civilization runs head on into our traditional values, we get all sorts of attempts to produce from out of a whirlwind of spiritual force. The editor has to voice something really substantial by reproducing the work of Jung in this anthology.

Psychological Problems of Cerebral Palsy, ($1.25. *The National Society for Crippled Children and Adults, Inc., 11 S. LaSalle St., Chicago 3, Ill.).* A symposium sponsored by The American Psychological Association and The National Society for Crippled Children and Adults. It deals with "Anatomical Facts," "Psychological Appraisal," "Counseling Parents" and Education.

Careers in Service to The Handicapped, ($0.50. *National Society for Crippled Children and Adults, 11 S. LaSalle St., Chicago 3, Ill.).* Information for vocational guidance specialists on the professions of physical therapy, occupational therapy, speech and hearing therapy and special education.

Group Counseling with Mothers of The Cerebral Palsied: Shall We Have Other Children?, by Harry V. Bice, Ph. D., ($0.50. *National Society for Crippled Children and Adults, 11 S. LaSalle St., Chicago 3, Ill.).* Contains the results of the total project of a cooperative effort by The State Crippled Children's Commission of New Jersey and an organized group of parents.

Medical Research: A Look Ahead, ($0.10. No. 758, NBC Radio Discussion, *University of Chicago, 37, Ill.).* A round table discussion of this topic, including also another on "How to Live a Hundred Years Happily."

Epilepsy—The Ghost Is Out of The Closet, Public Affairs Pamphlet No. 98, by Herbert Yahraes, ($0.25. *The Public Affairs Committee, 22 E. 38th St., New York 16, N. Y.).* A book of reassurance making it clear that thousands of individuals are being needlessly handicapped through ignorance and apathy of an otherwise enlightened public.

Alcoholism—A Sickness that Can Be Beaten, Public Affairs Pamphlet No. 118, by Alton L. Blakeslee, ($.25. *Public Affairs Pamphlets, 22 E. 38th St., New York 16, N. Y.).* Places the problem upon a scientific basis.

Your Neighbor's Health Is Your Business, Public Affairs Pamphlet No. 180—The National Health Council, by Albert Q. Maisel, ($0.25. *Public Affairs Pamphlets, 22 E. 38th St., New York 16, N. Y.).* Public health is purchaseable but it takes interest, and work on the part of the citizens as well as money.

How to Live with Heart Trouble, Public Affairs Pamphlet No. 184—The American Heart Association, Inc., by Alton L. Blakeslee, ($0.25. *Public Affairs Pamphlets, 22 E. 38th St., New York 16, N. Y.).* Helps both the patient and his family to meet his problem.

What We Can Do About the Drug Menace, Public Affairs Pamphlet No. 186, by Albert Deutsch, ($0.25. *Public Affairs Pamphlets, 22 E. 38th St., New York 16, N. Y.).* A thorough and balanced analysis of the present-day narcotic problems.

Food Poisoning and Food Hygiene, by Betty C. Hobbs, ($3.50. *Edward Arnold & Co., London, England.* United States distributor: *St. Martin's Press, Inc., New York 17, N. Y.).* This book aims to give to all concerned with catering, a clear account of the varoius causes of bacterial food poisoning which may spread, and measures for prevention.

School Health Education, by Delbert Oberteuffer, ($4.50. Revised Edition. *Harper & Bros., New York 16, N. Y.),* is a text for teachers, nurses, and other professional personnel, by the professor of physical education at the Ohio State University. It has been designed to give a comprehensive picture of the many aspects of the school health program and to describe current policies and procedures in this field.

The Traffic in Narcotics, by H. J. Anslinger and William F. Tompkins, ($4.50. *Funk & Wagnalls Co., New York 10, N. Y.).* In this volume the United States Commissioner of Narcotics and a Federal attorney for the District of New Jersey present an understanding study of the facts and evidence revealed in the Congressional investigation of crime and the steady stream of lurid newspaper stories of teen-age addiction, smuggling rings, and crime.

The Psychiatric Aide—His Part in Patient Care, by Alice M. Robinson, R. N., ($3.00. *J. B. Lippincott Co., Philadelphia 5, Pa.).* There is little formal training of these aides, and very few books written for them. This text undertakes to teach the aide how to create an atmosphere which will contribute to the recovery of the mental patient.

Design and Construction of General Hospitals, by The U. S. Department of Health, Education and Welfare, Public Health Service, ($12.00.

F. W. Dodge Corp., New York 18, N. Y., in collaboration with Modern Hospital Publishing Co., Chicago, Ill.). The book presents a unique collection of much-needed data on hospital planning and construction.

The Physician's Responsibility as a Leader, by Lewis Albert Alesen, M. D., ($0.75. *The Caxton Printers, Ltd., Caldwell, Idaho)*. The author meets the fundamental issue of our times—the issue of individual liberty and freedom versus collectivism—on a biological basis. Under biologic law, Nature selects the individual most eminent and rewards the individual for individual merit, and insists upon individual penalty for individual failure. Nowhere in societies below that of man does Nature of her own volition permit the individual to transfer responsibilities to the group. Everyone—layman and physician—should read this book.

Pregnancy Wastage, edited by Earl T. Engle, ($8.50. *Charles C. Thomas Publishers, Springfield, Ill.)*. The proceedings of a conference set up by the National Research Council to investigate what are the hazards of a fertilized human ovum from the time of conception until a child is born. This book, therefore, deals with the total post-conceptual reproductive deficit.

Fashion and The Unconscious, by Edmund Bergler, M. D., ($5.75. *Robert Brunner, New York 36, N. Y.)* reverses the generally accepted dictum that fashion is a strictly feminine interest. The thesis is that clothes are a masculine invention thrust upon women to alleviate man's unconscious masochistic fear of the female body. It is the same diffuse fear which turns to terror in the male homosexual. After analysis of 100 male homosexuals, many of them connected with the fashion industry, the author reaches the conclusion that the unsuspecting women are the victims of a fashion hoax perpetrated by the unconscious of some designers. A separate chapter discusses unconscious tributaries to love and jealousy, and the connection with the misuse of clothes.

Operating Room Technique, by Anna Margaret O'neill, ($3.75, 3rd Edition. *F. A. Davis Company, Philadelphia, Pa.)*, is a text from the Ohio Valley Hospital at Wheeling, W. Virginia, which again endeavors to help the student develop an appreciation of aseptic operating technique. A new scrub-up technique has been attempted, as well as a chapter on dental surgery as it pertains to the operating room.

Obstetrical Management and Nursing, by Henry L. Woodward, M. D., and Bernice Gardner, revised by Richard D. Bryant and Anna E. Overland, ($5.75, 5th Edition. *F. A. Davis Company, Philadelphia 3, Pa.)*. Gradually it has become evident that a thorough knowledge of the reproductive process is a *sine qua non* for the intelligent management of obstetrical cases. The patient and the doctor need this knowledge, most of all the nurse is in need of it, for in many situations she is the doctor's own representative. It is with this point of view that Dr. Bryant of the Cincinnati General Hospital has revised this text.

Aids to Pathology, by John O. Oliver, ($2.50, 10th Edition. Imported by *Williams and Wilkins Co., Baltimore, Md.)*. A well-established member of the Student's Aid series. No major changes have been introduced, but opportunity has been taken to consolidate those made in the 9th edition by a careful revision of every chapter.

Physical Chemistry for Students of Biology and Medicine, by David Ingersoll Hitchcock, ($5.00, 4th Edition. *Little, Brown & Co., Boston 6, Mass.)*, is a brief text written for a short course designed to give the student accurate knowledge of the essentials of the subject.

Doctors, People, and Government, by James H. Means, ($3.50. *Little, Brown and Co., Boston 6, Mass.)*, is devoted to the thesis that the American people are entitled to the best medical service which science and art permit, and which they can afford to buy. They are entitled to get it at the lowest price consistent with high quality, or have it given them if they cannot pay. All of the people are entitled to medical service on these terms, and they are not now getting it. Dr. Means has been interested for many years in the social aspects of medicine, which he has studied from the viewpoint of his work in the Massachusetts General Hospital. His residence in these cloistered halls narrows his vision, gives him very little information as to how the great mass of Americans live, makes him unmindful of the principles upon which this republic was founded, and leads him to forget the basic law of Nature that each biological unit is an individual and that only in the case of Man does Nature allow the group to take over the functions of the individual. Therefore he sees the solution to our problem in working out a particular cooperation between government and private and voluntary medicine which he believes can be done in harmony with our total social and structural pattern. This pontifical pronouncement from Back Bay will not be acceptable to people who live over the mountains in the western world.

The Webb of Life, by John H. Storer, ($3.00. *The Devin-Adair Co., New York 10, N. Y.)*, is not only a useful treatise on ecology, but also a most interesting book because of the vision and experience of its author. The wise use of all the things about us must be based upon a knowledge of the action and interaction of all things in the community round about. As Fairfield Osborn says in the introduction: "The aim of this book is to make that compelling truth clearer. The youngster captive on the sidewalks of our big

cities, the farmer struggling in a dust bowl, the sullen river that once ran silver, the desolate tangle of second growth, even the last condor on the California mountaintop—all have a tenuous relationship to life on this earth as a whole. Man does not stand alone. The balance of Nature is a complex job, told here in simple language and presented with clarity."

The Psychiatrist: His Training and Development, ($2.50. *The American Psychiatric Association, 1785 Massachusetts Ave., N. W., Washington 6, D. C.),* is a partial report of the conference on psychiatric education held at Cornell University in 1952. It focuses attention primarily on the training of career psychiatrists. The Editorial Board in the report of the Conference gives the results of the Conference Members' constructive thinking upon the broad subject of the training and development of a scientist.

The Revival of Interest in The Dream, by Robert Fliess, M. D., ($3.00. *International University Press, Inc., New York 11, N. Y.),* critically surveys the bulk of psychoanalytic literature on the subject. The author reviews what has been achieved, places the new contributions within the general framework of reference of Freud's work, discusses the controversial subjects, and lastly presents a monograph study on "Direct Speech in the Dream."

A Cook Book for Beginners, by Dorothy Malone, (35¢. *Ace Books, Inc., New York, N. Y.).* For the men amongst us who enjoy cooking, Miss Malone gives the basic recipes a flair that lifts them out of the ordinary. Most of her recipes are scaled to serve two, and with a bit of glamour too.

Review of Physiological Chemistry, by Harold A. Harper, ($4.00. 4th edition. *Lange Medical Publications, P. O. Box 1215, Los Altos, Calif.),* presents the fundamentals of the subject with emphasis on accepted facts and concepts. A wise presentation of the applied and established principles is favored over the theoretical and controversial. It is intended, therefore, as a supplement to the standard texts on biochemistry.

Methods in Medical Research, Vol. 6, J. Murray Steel, Editor-in-Chief, ($7.00. *The Year Book Publishers, Inc., Chicago 11, Ill.),* is another in the series of volumes designed to stimulate and help medical research. This volume, like its predecessors, is the work of many authors. Methods of studying human genetics is under the direction of Antonio Ciocco. Environmental medical research is by Ray G. Doggs, Statistics in Medical Research by Donald Mainland, the design and construction of metabolism cages under Arnold Lazarow. By having compressed into a single volume the methodology of medical research, the book becomes a most useful tool. In the meantime the general reader will find the approach to the problem of equal interest.

A Psychological Study of Eminent Psychologists and Anthropologists, and a Comparison with Biological and Physical Scientists, by Anne Roe, ($1.50. *The American Psychological Association, Inc., 1333 - 16th St., N. W., Washington, D. C.).* Another in the series of psychological monographs—general and applied. This is the third in a series dealing with clinical studies of research scientists. The majority of the men whose lives are studied came from lower to upper middle-class backgrounds, and nearly half of them had fathers who were professional men. They were all married, and most of them had children. Early interest in literature and the classics was common. The psychologists were relatively late in determining upon a profession, because the subject is not taught in high school nor in the first years of college. All but two came from Protestant homes, none from Catholic homes, and most had some religious training. Only two of the twenty-two men are now interested in the church. On the Rorschach, the social scientists are remarkably productive, rather uncritical, and somewhat haphazard in their use of rational controls. They are intensely concerned with persons, frankly aggressive, and often troubled with conflicts over domination and authority.

Speech Therapy, A Book of Readings, edited by Charles Van Riper, ($3.95. *Prentice-Hall, Inc., New York 11, N. Y.).* A collection of supplementary readings for studies in speech correction. In a new field such as speech therapy, many contributions are scattered in various journals and texts which may not be available in the library at hand, and hence this collection of 179 essays.

Diseases of the Chest, by T. Royle Dawber, and Lloyd E. Hawes, ($10.00. *Williams & Wilkins Co., Baltimore 2, Md.),* fills a need of the general physician for a complete, authoritative, and yet simple guide to the diseases of the chest and the use of the x-ray in their examination. The senior author is an internist and the junior is a roentgenologist. They have worked together for a long time as a team.

Clinical Roentgenology; Vol. 1, by Alfred A. de Lorimier, M. D., Henry G. Moehring, M. D., and John R. Hannan, M. D., ($18.50. *Charles C. Thomas Co., Springfield, Ill.),* grew out of the impetus given to the three authors when they were assigned to teaching activities at the Army Medical School in Washington, and later at the Army School of Roentgenology, Memphis, Tenn. Dr. Hannan is one of our own members, being radiologist to the Memorial Hospital in Painesville, Ohio. This volume is devoted to the developmental and systemic conditions and local lesions in the extremities, and the importance of assembling as many diagnostic features as possible before arriving at a diagnosis is strongly emphasized throughout the text.

The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 50 August, 1954 No. 8

JONATHAN FORMAN, M. D., *Editor*

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The Treatment of Infected Bone Cavities By Primary Bone Graft

RUSSELL P. RIZZO, M. D.

THE recent World War and the present Korean conflict have brought an abundance of compound fractures with accompanying infection and subsequent persistent drainage. With so many such problems and with the advent of the various antibiotics to control infection, it was only natural that some courageous and enterprising surgeons should attempt bone grafting even in the face of infection.

Most authors feel that any bone grafting in the presence of infection is unsound. Dickson[1] as late as 1944 stated in the Instructional Course Lectures that "the presence of infection in bone and soft tissue is a definite contraindication for bone grafting procedures." In two Army General Hospitals, the policy was that there would be no bone grafting if there had been any evidence of drainage or infection in the previous six months. Also, basic fundamental teaching in orthopedics strongly advises against primary bone grafting in infected areas. However, I would like to report several cases in which bone grafts were used in infected bone cavities with results gratifying to both surgeon and patient and to discuss the indications, contraindications, essentials of treatment, and value of this therapy.

Chronic osteomyelitis is characterized by the presence of infected bone and soft tissue coverings with destruction and ineffectual attempts at healing. Various shaped cavities containing frank pus, infected or indolent granulation tissue, necrotic fibrous tissue and sequestra are formed. These may or may not communicate with the surface of the bone or limb by sinus tracts. There is subperiosteal and endosteal bone formation with partial or complete obliteration of medullary and Haversian canals with thickened cortex and periosteal covering. All this makes for a poor blood supply to the area and in chronic cases systemic drugs fail because they cannot cross these barriers to the involved area. The failure of medical treatment despite antibacterial substances points to the need for wide excision of the focus, thus making it possible for drugs to reach the area.

The Author

Dr. Rizzo, Cleveland, is on the staffs of St. John's, St. Vincent Charity, Lakewood, Fairview Park, Evangelical Deaconess, Lutheran, and Berea Community Hospitals.

PROGRESS OF THERAPY

Techniques such as Carrol-Dakin, Orr, Bipp or maggotts following thorough debridement with healing by secondary intention have been used for years with some good results. However, these methods are prolonged and tedious, and often leave permanent fixed deformities.

The next advance in therapy was adequate

Presented at the annual meeting of the Ohio Orthopedic Society at Lakewood Hospital, Cleveland, Ohio, April 1953.

Submitted January 21, 1954.

saucerization, and then secondary coverage with split-thickness skin grafts advocated by Armstrong and others in 1936. This provided a method for dealing with bone cavities after radical operation.

Then followed the definite swing to primary closure after adequate saucerization, combined with antibacterial drugs, both local and systemic. In 1941, Dickson and Diveley et al. closed 22 bone cavities primarily using oral and local sulfathiazole and showed that 82 per cent healed by primary intention. They believed their failures were due primarily to lack of proper tissue covering for bone. J. Albert Key, in 1944 reported that primary closure using sulfonamides was better than any treatment so far, and showed that 40 per cent healed primarily, 35 per cent healed after minor difficulty, 10 per cent recurred and 15 per cent needed amputation.

In 1946, McKelvey[2] reviewed 50 cases that had saucerization and then secondary closure with 70 per cent healing primarily and 86 per cent healed at the end of one month. Brandon Carrell and Woodward used primary closure on 49 patients, mainly children, with 82 per cent healing primarily, 40 per cent showing some degree of recurrence and 16 per cent needing additional surgery.

Buchman[3] reported 93 lesions treated by primary closure with aureomycin, with 79 per cent healed by primary or delayed primary intention. Guy Caldwell in discussing Buchman's paper stated that "some of the most difficult cases are those with large cavities in which it is impossible to saucerize bone or flatten soft parts and skin against bone." He used iliac bone grafts in a few cases with good results. Many investigators have attempted to solve the problem of filling large infected bone cavities.

In 1945, Lt. Col. Knight[4] at Crile General Hospital in Cleveland reported 23 cases treated with sequestrectomy, early split-thickness skin graft and then bone graft with full thickness pedicle or transfer of full thickness skin. All but two healed. Lt. Col. Prigge, in 1946, preferred to obliterate cavities with muscle when available in 64 cases: In 20 cases treatment was by bone graft. Eight cases had good results, eight took longer than ten weeks to heal and four were failures.

It has been shown by Buchman that oxycel® and gelfoam® are definitely not satisfactory to use for obliteration of bone cavities.

Jowett in 1950 reported the treatment of 53 infected cavities filled with soft tissue, muscle or bone chips. He preferred using soft tissue, since in a series of 43 cases, 37 healed per primum.

At the Mayo Clinic, Bickel and Bateman reported 13 cases with three failures. They felt that autogenous bone was superior, and that more rapid and more permanent healing could be obtained by this method but advised caution.

The largest and most impressive series was 52 cases reported by Coleman, Bateman and others[5] in Toronto. All of the cavities were infected. They used cancellous chips, penicillin and sulfonamides in the wound. They reported four failures. Thirty cases required some type of plastic procedure.

Mather Cleveland et al.[6] in 1952 showed two cases of non-union of the femur treated with bone grafts in the presence of infection which healed in spite of slight drainage after surgery.

With this background of the evolution of the treatment of osteomyelitis and the associated apparently good results, and with the premise that if radical excision of all avascular and infected tissue could be accomplished and the dead space obliterated and the wound closed, all factors for prompt healing would be present, it seems logical to assume that the proper use of bone grafts to obliterate infected bone cavities should have a good measure of success and be worthy of trial.

ESSENTIALS OF TREATMENT

In my opinion, the following principles appear to be essential:

1. **Adequate skin coverage:** A careful evaluation of the skin problem is of paramount importance and must be carefully planned. Procedures that may be used are (a) local mobilization of skin edges, (b) rotation flaps, (c) local pedicles and, (d) cross leg or abdominal pedicle flaps. There must be good skin closure without undue tension and no drains.
2. **Specific antibiotic protection:** Pre- and postoperative antibiotics are used following culture and sensitivity tests for specific antibiotics. Those used alone or in combination are penicillin, sulfonamides, terramycin® and aureomycin.
3. **Complete sequestrectomy, saucerization and debridement of all abnormal tissue.**
   (a) *Pneumatic tourniquet* is used to permit better visualization of deep cavities.
   (b) *Sinus tracts* are injected with methylene blue and hydrogen peroxide to stain the complete extent of the involved area.
   (c) *Adequate vascular bed* with raw bleeding bone must be formed for
      1. bone grafts;
      2. elimination of drug barrier.
4. **Autogenous cancellous iliac chip bone grafts** are preferred since these have been shown to (a) rapidly revascularize, (b) readily become incorporated into host bone and (c) do not tend to sequestrate in presence of infection

like cortical bone does. Second choice is bone bank rib.

5. **Obliteration of all dead spaces.**
6. **Plaster immobilization.**

CONTRAINDICATIONS

The contraindications for bone grafting in infected bone cavities are:

1. **Severe acute infection.**
   (a) Acute hematogenous osteomyelitis. This is usually better treated using sulfonamides and antibiotics than surgery. Lenox Baker in 1944 reported 30 cases treated by incision and drainage with 66 per cent still draining and 26 cases treated closed with antibacterial drugs with 15 per cent still draining.
   (b) Severe, acute fulminating recurrent infections with large quantities of pus.
2. **Extensive lesions of skin or bone with marked loss of substance and excessive scar tissue.** Many of these require amputation. Theoretically, large cavities over about three inches in diameter would present the problem of revascularization of the center of the grafted area.

INDICATIONS

The indications for using bone grafts in infected bone cavities are:

1. **To eliminate dead space** in
   (a) Chronic infected bone cavity circumscribed within the confines of bone itself with no break in cortex or sinus tract, such as a Brodie's abscess.
   (b) Chronic infected bone cavity with or without sequestra, with sinus with low grade infection and drainage.
2. **To obtain union** in infected non-union or delayed union with marked bone loss.
3. **To close saucerized cavities** which have been covered with split-thickness grafts with resultant low grade drainage.

CASE REPORTS

Case 1. A 37 year old colored male who fell three floors in August, 1951, sustained severe bilateral compound fractures of the distal tibia and fibula. He was in casts five months, then six weeks in traction. Drainage never stopped.

He was first seen in August 1952, one year after injury, draining moderate amounts of pus through anteromedial and lateral sinuses.

On October 28, 1952, at Charity Hospital, operation consisted of excision of both sinuses, removal of multiple sequestra, extensive saucerization, autogenous iliac chip grafts, primary closure and cast. Total hospitalization was about three weeks. Wounds healed per primum. He is now 15 months postoperative, the incisions have remained healed without drainage, and there has been no recurrence.

Case 2. A 59 year old white male sustained severe comminuted fractures of the middle one-third left femur on January 7, 1948. He spent a total of 19 months in spica casts and had three operations, the last operation being in September, 1951.

He was first seen in January, 1953, with non-union of the femur and a draining sinus, anterior thigh. On February 2, 1953, at Lakewood Hospital, operation consisted of excision of the sinus, complete debridement of fibrous-tissue at the non-union site and removal of several definite sequestra, intramedullary nailing and autogenous iliac chip grafts, and spica cast. Total hospitalization was about three weeks. The lesion healed per primum and now one year postoperative the femur has united. There has been no recurrence, and patient is ambulatory.

Case 3. This young male sustained a shell fragment injury in 1944 in France, with resultant compound fractures of the right distal tibia and fibula. He was hospitalized 23 months and had 15 operations, but continued to drain.

The patient was first seen in March, 1948, at Crile Veterans Administration Hospital. A sequestrectomy. followed with split skin graft, was done. He continued with slight drainage until November, 1950, when the above procedure was repeated.

On January 16, 1951, at Crile Veterans Administration Hospital, operation was extensive and consisted of saucerization, grafting using chip rib bone bank graft, relaxing fascia incision, and primary closure and cast. The wound healed per primum. He was given aureomycin and penicillin postoperatively. He is now three years postoperative, plays 36 holes of golf, is working and there has been no recurrence.

Case 4. A young colored male with extensive tuberculous involvement of lungs, pleura, peritoneum, abdominal wall, thoracic spine, and both tibiae.

On April 4, 1950, at Crile Veterans Administration Hospital, extensive excision of an infected cystic area in the left tibia was done. Fifteen cubic centimeters of thick yellow purulent material with red granulation tissue and sclerotic wall was found and removed. The cavity was packed with chips and toothpick bone bank rib grafts. A cast was applied and the patient put on penicillin and streptomycin. There was no postoperative elevation of temperature. Guinea pig and acid-fast stains were positive for tuberculosis.

On September 30, 1951, spine fusion at T1-T5 for tuberculosis, was done. He is now almost four years postoperative and the lesion has remained healed with no drainage.

Case 5. A young male with onset of pain above the right ankle in 1944, following acute otitis media and mastoidectomy at Great Lakes while in service. He was first seen at Crile Veterans Administration Hospital in March, 1952, with tenderness over the distal right tibia with no excessive swelling or increased heat. X-ray impression was fibrous dysplasia or local Brodie's abscess.

On March 20, 1952, at Crile V. A. Hospital, the lesion was curetted completely and packed with autogenous cancellous iliac bone chips. The wound healed per primum. He is now about two years postoperative and has remained healed with no recurrence.

Case 6. An elderly male who sustained compound, comminuted fractures of the right proximal tibia and fibula on October 15, 1950, in an auto accident. He was operated upon elsewhere.

He was first seen in February, 1951, at Crile V. A. Hospital. On February 15, 1951, a se-

questrectomy was done and the wound packed open and a cast applied. On April 7, 1951, a delayed tibial graft was raised. On May 8, 1951, a tibial bone graft was done through the windowed cast. Eleven days postoperative, there was some central necrosis of skin. Four months later he was readmitted healed. The skin broke down on October 22, 1951, and on November 16, 1951, saucerization was done. No sequestra were found and the skin was closed under tension. The wound broke down slightly but was completely healed one month postoperative.

He was last seen on July 15, 1952, with no complaints, no pain and no drainage. He is now about 2½ years postoperative.

Case 7. A 17 year old white male was first seen in October, 1951, with severe pain in the right forearm and wrist with swelling, tenderness, increased heat, limited motion and high temperature. Four years previously, he had had an ear infection and mastoid operation followed by mild aching in the right wrist which was called arthritis. Roentgenograms revealed an osteolytic lesion of the distal radius, either osteogenic sarcoma or acute osteomyelitis.

On October 29, 1951, at St. John's Hospital, complete debridement of the area and biopsy were done. The diagnosis was chronic infection and granulation tissue. The wound was closed and healed per primum. A cast was used to protect the wrist joint. The bone cavity filled in and bone graft was not necessary. He is now over two years postoperative and has remained healed without recurrence.

Case 8. The patient, a 54 year old colored woman had onset of hematogenous osteomyelitis at six years of age. She had an extensive lesion of the right tibia with the entire tibia exposed, drainage and scar tissue.

In July, 1951, at Charity Hospital, in two stages the entire tibia was extensively debrided down to vascular bleeding bone and skin closed and healed per primum. There was no large cavity, so bone graft was not necessary.

She is now 2½ years postoperative, still healed with no drainage or recurrence.

SUMMARY

Eight cases are reported. Six cases had large infected cavities which were obliterated by bone grafts. All of these, but one, healed per primum. Three cases had persistent draining sinuses with multiple sequestra, two following severe compound fractures and the other a non-union of the femur. One case was a saucerized tibial cavity that had been covered with split-thickness skin several times with persistent low grade drainage. Two cases were localized bone cavities confined within the bone, one being tuberculous. The remaining two cases did not have bone grafts but just skin closure after extensive saucerization and debridement. Both cases healed per primum. Longest follow-up is four years, shortest one year.

I feel that this one stage method of obliterating infected bone cavities with bone grafts has a definite place in the treatment of osteomyelitis, and in selected cases is the treatment of choice. In the treatment I would like to stress adequate skin coverage, specific antibiotic protection, complete sequestrectomy and saucerization, autogenous cancellous iliac chip grafts, obliteration of all dead space and plaster immobilization.

Acknowledgment is gratefully made to Drs. W. H. McGaw, C. G. Barber, N. Rosenberg, and C. Alfred for their kind help.

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Garbage-Borne Diseases in Swine

Garbage serves as an excellent vehicle for transmission of viral, bacterial and parasitic diseases in swine. Hog cholera, vesicular exanthema, foot-and-mouth disease, salmonellosis, tuberculosis, brucellosis and trichinosis are all transmitted in garbage or by feeding of infected meat.

Hog cholera is the most important porcine disease in the United States, but fortunately this disease is not transmitted to other animals or to man. Vesicular exanthema produces heavy losses among pigs, the only animals that are naturally susceptible to this disease. Foot-and-mouth disease affects not only hogs, but also other cloven-footed animals. Trichinosis affects swine and at least 25 other species of animals Its chief economic importance lies in the danger of infection of man from eating of trichinous pork.

All four of these important diseases of swine are associated with the practice of feeding of raw garbage. Their control, therefore, depends upon elimination of feeding of raw garbage to hogs. Uniform State and Federal regulations are needed for control of garbage feeding. Canada and Great Britain have had success in controlling these diseases by requiring that garbage which is fed to swine must be cooked. Atlanta, Georgia, has found incineration to be the most efficient and economical method of disposing of garbage.—JAMAS H. STEELE, D. V. M., veterinary director, Communicable Disease Center, U. S. Public Health Service, Atlanta, Georgia.

Abstract of paper presented at 1952 National Conference on Trichinosis, Auditorium, American Medical Association, December 15, 1952.

A Case of Rupture of the Cervix

HANS SEIDEMANN, M. D.

EVERY labor is accompanied by injuries to the cervix.[1] Lacerations usually occur in radial fashion and are caused by rapid dilatation, a large fetus or a pathologic condition of the cervix, particularly anatomic rigidity. Annular or circular detachments[2, 3] of the cervix have been reported in the literature in a few instances and have been attributed to dystocia from cervical stenosis while uterine contractions are strong. There are no reports in the literature on rupture of the cervix during labor. This is the reason for the publication of the following case.

The Author

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CASE REPORT

The patient, a 26 year old nullipara, was first seen on December 31, 1951. Her medical history revealed that she had typhus fever in Europe at the age of 20. She stated further that she had a vaginal operation in April 1951 in Germany because of a "growth," the nature of which was not known to her. Menarche started at the age of 19 and menses occurred irregularly at intervals of one to three months lasting six days, with a normal amount of flow associated with cramps. Her last menstrual period was November 6, 1951.

Initial physical examination revealed no abnormalities. The uterus was enlarged to the size of a six weeks old pregnancy. Blood pressure and urinalysis were normal and remained normal throughout the entire pregnancy. Serologic test for syphilis was negative, the RH factor positive. The estimated date of confinement was approximately August 15, 1952.

The patient was admitted to the hospital in early labor on August 22 with uterine contractions ten minutes apart. The fetal head was at -1 station, the cervix effaced and 1 cm. dilated. The fetal heart was heard in the left lower quadrant. Five hours after admission the contractions occurred at 2 to 3 minute intervals, the cervix was 4-5 cm., station zero. At that time the patient received demerol® 100 mg, seconal® 3 gr., and scopolamine 1/150 gr.

Contractions continued with increasing severity and were noted to be violent. She was ready for delivery 2½ hours after the first administration of the medication. The fetal head was crowning at the vulva. The baby was delivered in the usual fashion by means of a right mediolateral episiotomy and outlet forceps from right occipito-anterior position under terminal spinal anesthesia. The baby weighed 3100 grams. The placenta followed on moderate pressure on the fundus.

On routine inspection of the cervix it was noticed that there was a large transverse perforation of the posterior aspect of the cervix extending from one lateral margin to the other, leaving a narrow bridge of apparently normal cervix between the perforation and the posterior cervical lip. The edges of the perforation were slightly ragged but the tissues surrounding the perforation had a normal appearance and showed no signs of trauma. The rent was repaired by several Number 00 chromic catgut sutures which were tied loosely. The episiotomy was repaired in layers in the usual fashion. The postpartum course was uneventful. The patient was discharged on the fifth day.

Examination of the patient five weeks postpartum disclosed that the repair of the rupture of the cervix was unsuccessful. The cervix appeared to have a posterior laceration extending vertically from the posterior cervical lip to short of the posterior vaginal vault. The perforation which was originally central and away from the external cervical orifice had developed into a deep vertical laceration. The above mentioned

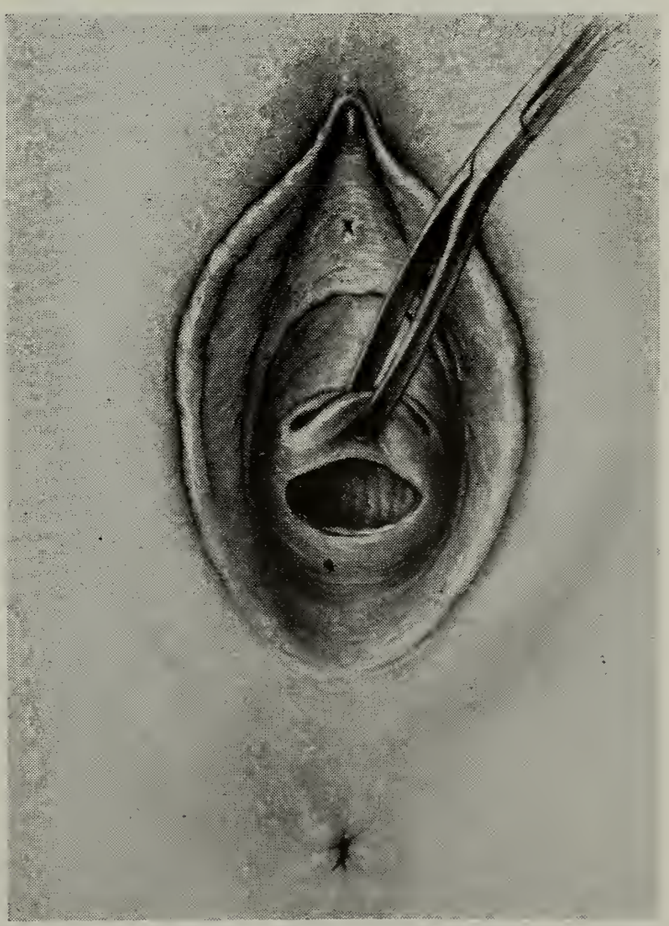


Fig. 1. Perforation of the posterior surface of the cervix with cervical os intact.

Submitted June 19, 1953.

bridge had disappeared. The patient was scheduled for surgical repair of the laceration but did not return.

COMMENT

The rupture of the cervix in form of a central perforation of its posterior surface at the time of delivery gives rise to the question of the etiology. In this particular case it was noticed that the patient had violent contractions which could not be controlled by the usual analgesics. They could have been responsible for the occurrence of the perforation. Information as to the nature and site of the "growth" which was removed surgically from the vagina of the patient in Europe would have been valuable but could not be obtained. It is possible that it was located at the posterior surface of the cervix and has left a locus minoris resistantiae.

No abnormal findings of the cervix were noticed at the time of the first examination. Neither was there a cervical stenosis which is said to be the cause of annular lacerations of the cervix during labor. A biopsy from the edges of the perforation would possibly have been informative but was avoided out of fear that it might interfere with the healing.

It was mentioned that the immediate repair of the perforation was not successful. The blood circulation in the narrow bridge of tissue between the perforation and the posterior cervical lip must have been sufficiently disturbed to interfere with the healing. The possibility of trauma by a faulty application of the blades was considered but can be excluded as the fetal head was crowning at the vulva at the time of the delivery and no cervix could be palpated by the examining finger prior to the application of the blades.

SUMMARY

The case of a central perforation of the posterior aspect of the cervix at the time of delivery is described the etiology of which is not known.

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Diabetes in Pregnancy

An imbalance of female sex hormones, disturbed water balance and pre-existing vascular disease appear to affect the course and outcome when pregnancy complicates diabetes.

The imbalance of sex hormones may be conditioned in the diabetic by vascular disease or by rapid maturing and senescence of the placenta—the former a part of the total diabetic vascular disease and the latter due to hyperglycemia or hyperpituitarism.—Priscilla White, M. D., Boston, Mass.: *Rocky Mountain M. J.*, 51:357, May, 1954.

KEEPING UP WITH MEDICINE

• A LARGE, as yet untapped, source of natural drugs is the seeds of flowering plants. These produce chemicals which bid to be as important to human health in their effect against viruses as antibiotics made by the molds.

* * *

• IN THESE DAYS of chlorophyll, the canker sores of which the patient complains may be due to the glorified tooth paste or breath sweeteners containing this "magic chemical."

* * *

• THE EDEMA of pregnancy is primarily a physiological edema and is thought to be due to an increased sodium retention with the water held in the interstitial tissue along with about 29 liters which is already there.

* * *

• ABOUT ONE-THIRD of the entire group of cerebral palsied children have been found to be uneducatable by reason of mental deficiency.

* * *

• LOWER blood levels of serum blood iodine occur more often in abortion and threatened abortion.

* * *

• BURSITIS is the cause of about 80 per cent of all cases of painful shoulder.

* * *

• THE PATIENT with heart disease often finds it uncomfortable to lie on his left side because he then becomes overly conscious of his heart beating against the bed.

* * *

• BREATHING EXERCISES provide the most effective physiotherapeutic tool for patients with emphysema. The principle of these exercises is to minimize inspiration, which is the active respiratory phase, and to emphasize the normally passive expiration of air.

* * *

• STUDIES OF BIOPSY specimens fail to support the view that mucosal atrophy, atrophic gastritis, or any generalized mucosal disease should be considered a normal consequence of aging.

* * *

• STUDIES OF PEOPLE with heart failure show a persistent negative nitrogen balance and protein deficiency.

* * *

• RECENT INVESTIGATIONS suggest that hormonal balance may have an important influence on the protein and lipoprotein factors of the body which, in turn, influence arteriosclerosis.

* * *

• FUNCTIONAL spontaneous hypoglycemia may simulate organic hyperinsulism. It usually occurs in nervous and unstable persons.—J. F.

Leiomyoma of Esophagus—Report of Case With Successful Enucleation

CHARLES M. OXLEY, M. D.

REPORTS of successful surgical removal of benign intramural tumors of the esophagus are sufficiently rare that any individual case is worth reporting. Leiomyoma of the esophagus, the most common of benign esophageal tumors, is a smooth muscle tumor that originates in the muscularis. Grossly the tumor is a firm, rubbery, pinkish-gray, homogeneous, irregular mass. It appears most often in the distal esophagus, next in the middle third, and least in the upper third.

DIAGNOSIS

There are no symptoms of diagnostic importance. Dysphasia of varying degrees, depending upon the size and location of the tumor, may be present. Occasionally there is pain at the level of the lesion either in the retrosternal area or in the back. Diagnosis is made by barium studies of the esophagus or by esophagoscopy. In either case, a tumor encroaching upon the lumen with no involvement of the mucosa is visualized.

The treatment is surgical. The approach depends somewhat upon the surgeon's preference. Usually if the tumor is in the distal esophagus or if a resection of the esophagus is anticipated, a left thoracotomy is the procedure of choice. In lesions of the mid-third and upper esophagus where esophageal resection is remote, the right-sided approach offers by far the better exposure.

RECORDED CASES

Myers and Bradshaw in 1951 reported 43 cases of benign tumor of the esophagus, 24 of which were leiomyomas. One case had two separate tumors. Sabiston and Scott in 1952, reporting on 101 cases of primary tumor and cysts of the mediastinum, listed one case of leiomyoma of the esophagus. Westerborn in 1952 reported a successful excision of an esophageal leiomyoma. A review of the literature at that time indicated 27 cases in which operation had been performed for esophageal leiomyomas.

Schnug in 1952 reported a most interesting case of leiomyoma involving the cardio-esophageal junction. In his case, a resection was necessary and an esophagogastric anastomosis was done. Zaslow and Krasnoff in 1953 discovered two more reported cases of benign tumor of the esophagus and added one case of their own which was leiomyoma.

Kenney reported in July 1953, a remarkable case of leiomyoma. This involved the distal two-thirds of the esophagus and upper one-third of the stomach. Bilateral thoracotomies as one consecutive operative procedure were required for the successful resection. The tumor weighed 1420 grams and is thought to be the largest ever to be resected successfully. It also was the fourth recorded case of survival following radical esophagectomy and esophagogastrostomy for esophageal leiomyoma.

Rabinovitch, Neissen, and Rabinovitch in August 1953, reported on seven cases of leiomyoma, two of which survived operation. The other five cases were autopsy findings and of no particular significance.

The total recorded surgical cases of benign esophageal tumor is fifty-two. Thirty-one of them are leiomyomas. This case represents the thirty-second case of leiomyoma with surgery and the fifty-third case of benign tumor of the esophagus with surgery. Of the fifty-three cases there have been three deaths.

CASE REPORT

The patient, a 38 year old white, married woman was admitted to the hospital February 8, 1953. In October 1952, she had had a routine miniature roentgenogram of the chest taken at her place of employment. This film was suspicious of mediastinal tumor, and in December 1952, a 14 by 16 film of the chest revealed the same tumor mass.

History: Close questioning revealed that for a period of about one year solid food occasionally would stick in the esophagus at a level beneath the upper sternum. A sip of water would relieve the condition. Pain, referred to the back at about the level of D-4 and at times referred to the anterior chest in the midline at the level of the manubrium, occurred when food would stick in her esophagus. Cold water and carbonated beverages occasionally would cause the same symptoms.

There had been no weight loss. Her past history was not contributory. She had an appendectomy in 1946. Family history revealed no similar trouble in her parents or in any of her three sisters and three brothers. Inventory by systems revealed a dry, unproductive cough at times. No hemoptysis. The remainder of the

The Author

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Submitted September 29, 1953.

systems history was negative or given in the present illness.

Physical examination revealed weight 123 lbs.: temperature 98.0, pulse 74, respirations 20; blood pressure 140/90. Patient was a well developed and well nourished white woman of 38 years of age. Ear, nose, and throat examination was negative. There were no enlarged lymph glands, and the thyroid was not palpable. Lungs were clear to percussion and on auscultation. Vital capacity was 2.7 liters. Peripheral arteries were easily palpated. The heart tones were of good quality, the rhythm regular, and no murmurs were present. Examination of the abdomen revealed a well-healed, right lower quadrant scar. Palpation revealed no pain, tenderness, masses, muscle spasm, or rigidity. Examination of the rectum. pelvis, and extremities was not remarkable. Neurological examination was negative.

Laboratory Data: The red blood count was 4.07 million; hemoglobin 80 per cent; white blood count 9900; polymorphonuclear neutrophil leukocytes 83; polymorphonuclear eosinophil leukocytes 2; lymphocytes 15; sedimentation rate was 22 mm. per hour; urea nitrogen 12 mg. per 100 ml.; serum protein 5.65 Gm.; albumin 3.75 Gm.; globulin 1.90 Gm.; urinalysis negative.

Barium studies of the esophagus revealed a tumor mass that encroached anteriorly upon the esophageal lumen about the mid-third of the esophagus. The esophagus above the tumor was dilated moderately.

On February 9, 1953, bronchoscopy revealed the lower trachea and right main stem bronchus to be pushed forward by a nonpulsating mass that seemed to lie posterior to the distal trachea and right main stem bronchus. There was no mucosal involvement, and it was the impression that this mass was extrinsic to the trachea and/or the bronchus.

On February 11, 1953, esophagoscopy revealed moderate dilatation of the proximal esophagus. At a level of eight inches from the upper incisor gum line, the anterior wall of the esophagus bulged markedly into the lumen constricting the lumen about 50 per cent. The bulging was due to a mass that extended for a distance of about three inches. In no area was the esophageal mucosa involved. The mass appeared somewhat movable and did not pulsate. The impression from this examination was that the mediastinal mass was located in the anterior wall of the esophagus involving the upper and middle thirds and was probably benign.

Operation: On February 18, 1953, the patient was operated upon. The right thoracic cavity was entered after resection of the fifth rib. The right lung was plastered to the pleura by rather dense adhesions. The upper and middle lobes were mobilized, and the pleura over the palpable tumor mass was incised. A tumor mass, 10 by 5 by 3 cms., was located within the muscular coat of the anterior esophageal wall. The mass was lobulated, whitish-gray in color, firm and rubbery in consistency. The azygos vein crossed over about its mid-portion.

The vena azygos was freed, doubly ligated, and cut. The esophageal mass was then dissected free by sharp and blunt dissection and easily removed. During the dissection, the esophageal mucosa anteriorly was violated for a distance of about 2½ cms. and was closed with interrupted sutures of 4-0 silk. The suture line was reinforced by suturing the muscle layers over the mucosal suture line. In all, three layers of sutures were placed. Since the right lower lobe was held expanded by pleural adhesions, the only drainage necessary upon closure was a water-seal drain inserted into the third interspace anteriorly. The chest was closed in layers using 3-0 cotton.

Five hundred thousand units of penicillin were instilled into the thoracic cavity after closure. During and after the procedure, the patient received 500 cc. 0.1 per cent procaine/saline, 500 cc. glucose/water, 1500 cc. blood, 2000 cc. 5 per cent beclysyl®/water with 500 mg. Vitamin C—all intravenously.

Postoperatively the patient did well. The highest postoperative temperature was 100.2° the evening of her first postoperative day. The right lung expanded well and remained expanded. Duracillin® was given, 1 cc. every 12 hours. Amigen® and fluids were given intravenously. Water was started orally the second postoperative day and soft foods the third. She was up and reacted well the third postoperative day. The thoracotomy drain was removed the fourth day. She was dismissed the eleventh postoperative day with her incision well healed and all sutures out.

The pathological report on the microscopic sections revealed a leiomyoma of the esophagus.

Follow-Up: This patient has been seen seven times since her operation, and she is doing well. At no time since the operation has she had food stick in the esophagus, nor has she been bothered with the back pain or the substernal discomfort.

SUMMARY

1. A case of leiomyoma of the esophagus with successful excision is reported.

2. A review of the literature indicates that this is the fifty-third reported case of benign tumor of the esophagus and the thirty-second case of leiomyoma of the esophagus that has had the benefit of surgery.

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Nummular Eczema

Nummular eczema is a unique type of eczematous dermatitis with fairly typical clinical manifestations.

Although there are several entities with which nummular eczema may be confused, once the circular or oval outline of the eczematous patches is noted, with normal skin between these patches, on the areas of predilection, the diagnosis of nummular eczema can usually be readily made. Lesions on the dorsum of the toes or feet may appear to be a contact dermatitis or a fungous infection. Townsend W. Baer, M. D., Pittsburgh: *Pennsylvania M. J.*, 57:230, March, 1954.

Simple Two-Stage Repair of Hypospadias By Means of the Denis Browne Method

BRUCE C. MARTIN, M. D., J. C. TRABUE, M. D., and MARY M. MARTIN, M. D.

HYPOSPADIAS is the most common congenital deformity of the male genitalia. The condition occurs in one out of 300 male births; [1, 2] however, approximately only one-fourth require surgery. The remainder consist of simple openings in the region of the corona.

Investigation by Sorensen[3] into the hereditary aspects of this condition shows that there must be an exogenous as well as an endogenous factor. Familial occurence is found in 28 per cent. It is felt to be a recessive characteristic. It is characterized by ventral curvature of the penis caused by a fibrosis of the tissue which should have formed the corpus spongiosum. Characteristically, there are present a hooded foreskin and various anomalies of the urethral meatus. Most commonly, the urethral meatus will open at the penoscrotal juncture; however, it may open at any point up to the level of the corona of the glans. In rare cases, the opening may be in the perineum. These are usually associated with cleft scrotum and often with an undescended testicle.

HISTORY

Since Dieffenbach in 1836 first described his efforts to cure hypospadias by piercing the glans with a cannula until epithelization occured, numerous other methods have been described. The first successful cure was reported by Anger in 1874, who used a modification of the skin flaps described by Thiersch. This involved fashioning the skin flap into a tube and covering the raw surface by another flap of skin in such a manner that the sutured edges were not in juxtaposition. In 1874, Duplay described a very similar type of repair. Since that time there have been numerous modifications of this principle described by Ombredanne, Blair, Padgett and others. McIndoe added a new thought by imbedding a skin graft around a cannula, thus forming a urethra, and, at a later date, anastomosing it to the existing meatus.

All these methods have been lengthy, time-consuming and fraught with many complications, particularly in the form of fistulae. Often many operations are required after the fundamental correction of the chordee is carried out.

In 1949 Denis Browne[4] reported a new operation for construction of a new urethra which differed quite radically from any previously described. The first step in his procedure is basically the same as in all other procedures, i. e., the correction of the ventral bowing. This is done by an incision along the ventral surface of the penis, exposing the fibrotic band and removing it in its entirety. The second part of his operation is completely unique in that it involves burying an isolated strip of skin and closing the tissue directly over it. Closure is obtained by making a dorsal relaxing incision. This gives a satisfactory urethra extending from the meatus to the corona and is functional in all respects.

The uniqueness of this procedure was apparent and the ease with which it could be carried out equally impressive. Since that time, we have used it to the exclusion of other methods. It is eminently satisfactory and relatively simple from the standpoint of surgical technique. We have used it in 11 cases with one slight modification. The cases with this modification are presented.

AGE

It is our feeling that no attempt should be made to start this reconstruction before the age of four. At an earlier age, the structures are extremely delicate, the excision of the fibrous band causing the chordee is very difficult, and delineations of fascia necessary for good closure are most difficult.

INFECTION

We feel that it is very important that there be no evidence of infection in the urinary tract or evidence of back pressure on the ureters or

Submitted December 11, 1953.

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kidneys before starting reconstruction. Sphincter control must be definite and adequate.

DELINEATION OF SEX

In cases of cleft scrotum and perineal openings it may be necessary to prove the sex of the individual by exploratory laparotomy.

METHOD

First Stage: The method of repair consists very briefly of two steps. An incision is made from the corona to the meatus. The meatus is circumscribed and allowed to retract. The skin flaps are elevated and the fibrous rudimentary corpus spongiosum is carefully dissected out. The wound is then closed with a non-capillary type of suture. A zig-zag incision reduces any tendency toward contracture of the skin. When carrying out the closure, the flaps are interdigitated in the manner of a multiple Z-plasty to give added length. (See Figure I.)

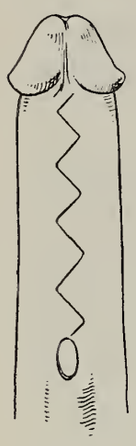


Figure I

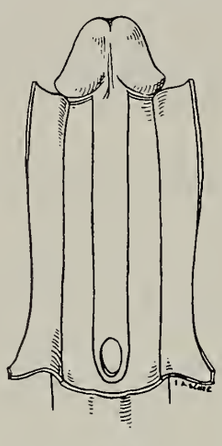


Figure II



Figure III



Figure IV

Fig. I. Illustrates the zig-zag line following chordee repair.
Fig. II. Shows central island of epithelium with flaps widely resected.
Fig. III. Shows the closure.
Fig. IV. Cross section.

Second Stage: Following the first procedure, complete absorption of the scar must take place. After a period of several months, when complete softening of cicatricial tissue has occurred, the second stage is performed. The first fundamental of success is diversion of the urinary stream. A sound is inserted into the bladder and a perineal urethrotomy made by simply cutting down on the sound. A mushroom or Foley catheter is inserted. The former is probably better because the bag of the Foley catheter may cause frequency and urgency.

This wound is usually closed with fine catgut. The urethral construction is then started by making two parallel cuts from the corona to and encircling the meatus, approximately one centimeter apart (Fig. II). No attempt is made to elevate this island of skin or to tube it. Lateral skin flaps are then elevated down to the dense fascia of the corpus cavernosum. This dissection is carried out very widely so that the skin edges can be brought together without tension. These flaps are then sutured together



Fig. V. Preoperative condition, showing penoscrotal hypospadias.

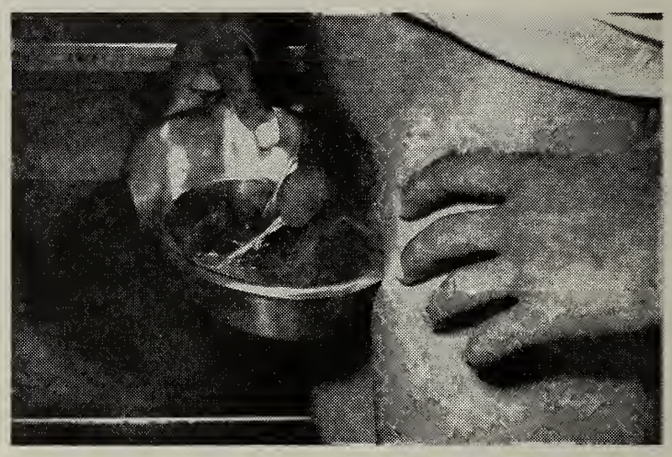


Fig. VI. Shows patient voiding. Note normal stream.

with fine chromic catgut in the layers of fascia and the skin is closed with a very fine non-capillary type of suture such as dermalon® (5-0). This completely buries the island of skin which will form a new urethra by epithelial extension from the sides. The penis is brought up on the abdomen and is dressed with moderate pressure to prevent extreme edema.

Skin healing is usually adequate by the seventh to the ninth day. The skin sutures are removed at this time under general anesthesia, unless the child is unusually cooperative. The urethrotomy catheter is usually removed two or three days later.

The only modification of the Denis Browne procedure, as outlined above, is that we feel it unnecessary to make a dorsal relaxing incision. Wide undermining of the skin permits omission of this step (Fig. III).

EVALUATION OF RESULTS

Eleven cases have been treated employing this method. In three cases fistulae occurred requiring a small secondary closure. The first

of these was one in which an attempt at repair had been carried out without a perineal urethrotomy. The remaining two cases in which fistulae occurred were done during a period when silk sutures were used in skin closure. Small suture abscesses developed which, it was felt, were due to the capillarity of the silk. Since using 5-0 dermalon®, no such difficulty has been encountered. The possibility of the complication of fistula formation, however, cannot be dismissed. Nevertheless, the ease with which the operation can be performed, the few stages necessary with this method, and the adequately functioning urethra which results, make us feel that this is the method of choice in the treatment of hypospadias.

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Tung Nut Poisoning

Tung nuts look good. The whole ripe nut looks like a large walnut and the unhulled seed is similar to a Brazil nut. Too, tung nuts taste good. The mature nut fresh from the tree has a sweetish taste like a chestnut, while the older, stored nut has a pleasant toasted almond flavor which is spoiled by the rancid after-taste which tung oil leaves in the mouth.

Tung nuts are toxic, and the cultivation of the tung tree for commercial and shade tree purposes is spreading. Because of these facts, especially the use of tung trees in urban areas where children have access to the nuts, tung nut poisoning is apt to be more and more common.

The major symptoms of tung nut poisoning are caused by a toxic protein, an albumin. Treatment, then, is symptomatic, as it is for any food poisoning due to a foreign protein.

Magnesium sulfate seems to denature the protein. Whether this change is accomplished by its cathartic action, by osmotic dilution of the offending protein, or by salting out of the protein by the sulfate ion is not known.

Concomitant with the use of magnesium sulfate, fluid and electrolyte replacement therapy is indicated, especially for those severely poisoned patients suffering from anaphylactoid reactions and potassium deficiency. Central nervous system stimulants and oxygen should also be used when indicated. In an extreme case, it is conceivable that intravenous corticotropin might be used.—Edward Balthrop, M. D., Pensacola, Fla., et al.: *J. Florida M. A.*, 40:813, May, 1954.

Early Tracheotomy in Bulbar Poliomyelitis

Those workers who advocate the performance of early tracheotomy in bulbar poliomyelitis maintain that tracheotomy has too often been looked upon as a measure of last resort and effects have been attributed to it which were due to the serious condition for which it was done, or to the fact that intervention came too late. They assert that to prevent anoxia is better than having to correct it after permitting it to happen, since damaged nervous tissue is particularly susceptible to oxygen lack and this damage is usually irreversible. If tracheotomy can avoid even one period of severe anoxia in these cases, it would be worth while, since the margin between life and death in these patients is so narrow that one such episode may kill them.

These workers advise tracheotomy:

(1) When, in spite of proper postural drainage and continuous pharyngeal aspiration, it is impossible to prevent pooling of secretions in the pharynx, resulting in spill-over into the airway, respiratory distress and recurrent cyanosis; in short, when there is progressive hypoxia accompanied by the presence of secretions in the pharynx.

(2) With stupor or irrationality sufficient to make the patient oblivious to the accumulation of secretions in his airway, particularly if he is in a respirator.

(3) If there is fluid accumulation and the patient later requires a respirator.

(4) In the presence of excitement and unmanageability, causing the patient to resist pharyngeal aspiration strenuously.

(5) If there is unconsciousness or pronounced restlessness in a patient who does not respond to other treatment in a few minutes.

(6) If there is pronounced restlessness (which often means air hunger) or stupor in a patient in a respirator, even if the paralysis is apparently only of the spinal type.

(7) When there is clinical or Roentgen-ray evidence of atelectasis, pneumonia, or pulmonary edema due to secretion in the lower airway.

(8) In the presence of rapidly progressive bulbar symptoms.

(9) In the presence of grave signs of vasomotor or respiratory center failure.

(10) When there is inability to cough effectively, especially if the patient is in a respirator.

(11) When there is a bilateral paralysis or spasm of the vocal cords.

(12) On the appearance of the "angle or rope dent" sign of Sjoberg.

(13) If the attendants are untrained or inefficient and the equipment is inadequate.—A. Harry Neffson, M. D., Tucson: *Arizona Medicine*, 11:89, March, 1954.

Management of a Patient with a Pollinosis With or Without an Associated Bronchial Asthma

JONATHAN FORMAN, M. D.

IT is to be understood that this paper is primarily a report to the allergists of Argentina on how one allergist in central Ohio, United States of America, manages patients who have become allergic to one or more pollens. Further than this, it is hoped that, while some of the remarks are limited in their value to those who practice upon allergic patients in the United States of America and more especially in the State of Ohio, since most of the suggestions are generally applicable this paper will have more than passing interest.

Of the many plants found in my area, only 44 produce pollens that are light enough to be windborne and possessed of antigenic properties so that they can be the cause of hay fever and/or pollen asthma. The list of these plants is appended.

SKIN TESTING

We make it a practice to do complete skin testing. The term complete, of course, is relative and by it I mean the 44 pollens mentioned above, 20 of the common protein inhalants and contactants such as danders, dust, etc., 108 of the foods eaten by my people. I, contrary to the opinion of many, have found it advisable to also test with pure cultures of the common bacteria encountered by these people. The lists of these are also appended.

We give instructions about avoiding all those substances which give positive tests and finally, in addition to those foods which give positive skin reactions, we watch very closely celery, tomatoes, chocolate, cucumbers, and other members of the melon family. The first year the patient is under our care we are not too well informed about his clinical reaction to these foods. We, therefore, ask patients to avoid them if any symptoms of a coryza develop.

In explaining the significance of skin tests to our patients, we have adopted an analogy to our criminal court procedures and tell them that we use skin testing as a detection tool comparable to taking finger prints at the scene of the crime. Finger prints thus taken may or may not aid in the identification of the person who committed the crime. Skin tests may be falsely positive or falsely negative but if they are positive and can be correlated with the symptoms, the skin tests to inhalants, foods, and bacteria (both immediate wheal and delayed type) are of great assistance and usually cut down the time and expense involved in the detection.

Prepared by invitation to be read at the Second National Congress on Allergy in the city of San Miguel de Tucumán, Republic Argentine, September 1953.

The Author

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REACTIONS TO POLLENS

In testing with pollens, however, the case is a little different. Here we seldom find a patient who has coryza or asthma from a pollen to which they do not give skin tests. Such a patient can only be identified by correlating his symptoms with the calendar of pollenation for the area.

We advise all of our patients that, while it is possible to go on an extended trip into areas where their offending pollen does not occur or does not occur at the same time as it does here in central Ohio, it is always best to attempt to gain complete tolerance for those pollens which turn out to be important by taking carefully graduated injections of the extract of these same pollens.

Occasionally, we encounter someone who has a prejudice against "serums" of any kind. To those persons we can say: "The materials used for the injections are not serums nor are they vaccines. They are only protein extracts of the pollens which you are bound to absorb when the next blooming season comes around. You cannot avoid taking this very material into your system in the same or larger doses. It is then only a question of the time and the method of absorption of the substance which you are going to get.

NOT A SERUM

"During the pollen season, every man, woman, and child in the area absorbs large doses of these same pollen extracts into their bodies. So you are going to take this same treatment material

into your system whether you want to or not, if you stay in central Ohio during the pollen season. Would it not be best, therefore, to do this gradually and gain a tolerance like 95 per cent of the people have rather than to wait and undergo the shock of having it literally dumped into your blood stream, through a protesting mucous membrane, without any preliminary preparation?

"If you take it slowly, before the season, in carefully graduated doses, you can build a tolerance, whereas, if you wait and get it in a huge dose all at one time, you will not only get no tolerance but also may lose the small amount which you already have. Hence, there is every good reason for taking the treatment and none for not doing so."

At whatever time of year patients consult us about these treatments for pollen, hay fever, and asthma, we tell them that the time to begin is now—"the sooner the better." For instance, if it happens to be in the middle of the season, properly planned co-seasonal treatment will give a lot of relief. By this we mean extremely small but increasing doses of aqueous extract injected at various sites into the skin *intra*dermally. The longer we have before the season, of course, the better the result which we may expect to obtain. But as Warren Vaughan said some years ago, "Now is the time to begin for year after next."

DOSAGE

Here in the United States there are two schools of thought as to the amount of pollen that the physicians use as their objective to attain as a maximum dose. The smaller group goes all out for extremely small dosage. Another, and somewhat larger group, goes all out for what are considered huge doses. The majority lean toward the large dose but do not go all out for it. It is my observation that those who have experienced many constitutional reactions, as well as those who insist upon avoiding all such are the ones who insist on the very small doses of very dilute extract. Most of those who use the extremely large doses give many more injections and increase the dosage much more gradually.

For the routine case my schedule very definitely belongs in the large dose school. In patients in whom co-seasonal treatment with intradermal injections of pollen is not giving the relief it should; in patients who come late in the season with severe symptoms who have not had treatment before or during the season; and in patients who because of "infectious colds," worry, anxiety, fatigue, unrecognized hypofunction, thyroid, and unusual exposures to non-specific dusts and fumes have developed severe hay fever in spite of a successful following of the hyposensitization program set forth in the following Table I, we now give 25 mgm. of cortisone acetate every 6 hours around the clock until 20 tablets have been used.

This is adequate therapy in all but a few cases and the suppression of the allergic symptoms will last from a few days, a week or two, or for the rest of the season. Upon their recurrence, the drug may be exhibited again in a similar dosage.

TABLE I
HYPOSENSITIZATION DOSE SCHEDULE

Solution		
Twice Weekly		
1 to 10,000	(volumetrically)	0.10 mgm.
1 to 10,000	"	0.15 "
1 to 5000	"	0.10 "
1 to 5000	"	0.15 "
1 to 2500	"	0.10 "
1 to 2500	"	0.15 "
1 to 1000	"	0.10 "
1 to 1000	"	0.15 "
1 to 500	"	0.10 "
1 to 500	"	0.15 "
1 to 200	"	0.10 "
1 to 200	"	0.15 "
Once Weekly		
1 to 100	(volumetrically)	0.10 mgm.
1 to 100	"	0.15 "
1 to 50	"	0.10 "
1 to 50	"	0.15 "
1 to 20	"	0.10 "
1 to 20	"	0.15 "
1 to 20	"	0.30 "
1 to 20	"	0.45 "
1 to 20	"	0.60 "
1 to 20	"	0.75 "

PRECAUTIONS

The patients are instructed to remain in the office for some time after the injection so that any constitutional reaction may be observed and managed in the office. They are also given an envelope with tablets containing ephedrine sulphate 25 mgm. and phenobarbital 16 mgm. with printed instructions on the envelope as follows: "If after you leave the office the wheal at the site of the injection shows a tendency to flare, if the palms of the hands or the nose or the palette begin to itch, if you begin to sneeze, or develop hives, or feel a tightness in the chest, swallow one of these tablets with water at once. The full effect of this tablet is obtained in about twenty minutes so in about half an hour you may take another. In the meantime, call us on the telephone. When you report for your next treatment you should always advise us of any itching, sneezing, or any of the above symptoms you may have had *before* we give you your next injection, thus avoiding reactions."

INSTRUCTIONS

Our patients are given a list of printed instructions which follow:

1. Where the results are not completely successful, often it is because there are other sensitizations which have not been given consideration.

We have taken every precaution in this regard. Therefore, you are to avoid during the season all the other things to which you gave a positive skin test. Such avoidance will lessen the allergic load sufficiently for the tolerance you have gained to control the symptoms due to the pollens alone.

2. Have no cut flowers of any description in your house.

3. See that the weeds in the vicinity of your house are cut before they bloom, and that they are kept cut at least once each month. This precaution is more or less futile because those pollens fly through the air at great heights and for distances of 50 miles or more, so unless the weeds are directly in line with the windows of your house, it is of little use to be concerned about them.

Interestingly enough, it is those weeds which so frequently are the cause of hay fever, namely plantain, lamb's quarter, pigweed, and ragweed that are really "friendly" weeds to the soil itself. They are deep-rooted and go down and bring up the rich mineral nutrients to feed the topsoil and the plants that grow thereon. So it is not so much the destruction of these weeds that we should organize to accomplish but rather the promotion of better management of the soil itself.

4. Do not take long rides through the country, play golf, or otherwise over expose yourself to the pollen. You have just a certain definite tolerance and whenever it is not adequate to your exposure, you will have symptoms.

5. Avoid the non-specific factors which will bring on attacks—dusty roads, house cleaning, chilling from going in swimming, fresh paint, perfumes and other fumes.

BATHING: Do not go into open pools or rivers during the height of the season. Take baths in a warm room in the morning rather than the evening—warm water—not hot—and be sure to dry off completely before coming out of the bathroom. In addition to the danger of the chilling bringing on an attack of hay fever, there is always the danger of an infection from a public pool with its head colds and sinus trouble. These, added to a hay fever, lay the groundwork for a permanent invalidism.

EXERCISE: It is to be remembered that getting heated and cooling off quickly will bring on an attack. As unnecessary as it seems, hay fever victims must be continually cautioned against out-of-doors sports during the season.

DIET: For the patient who is sensitive to certain foods, special elimination diets have to be planned. For the rest, plain, simple foods, not too rich, should be taken. Always make the noon meal the heavy one of the day and the evening meal a light one. Be sure not to eat any of the foods to which you have given a positive reaction.

6. **Window filters and air conditioning**, especially with a de-humidifier are a great protection and make the quarters much more livable.

7. **Nasal filters** are mentioned only to be condemned. If properly fitted, they do filter out the offending pollens but there are very few human beings who can consistently breathe through them. The temptation is always present to breathe through the mouth and thus deliver all the pollen to the bronchial tree. This predisposes with more certainty to bronchial asthma.

8. **Directions for the care of the eyes:** The irritation and production of mucous in the eyes can be controlled by proper washing and removing the offending material. For washing the eyes we use cold, saturated solution of boric acid with an eye cup. Immediately after the washing, the patient is instructed to instill 2 drops of a fresh solution of sodium carbonate (please note that this is sodium carbonate and not sodium bicarbonate). These washings may be performed as often as necessary to give comfort and the frequency will depend on exposure. If this regime is not adequate to control the eye symptoms then we use the commercial ophthalmic solution of antitistine® (Ciba). This insures relief but carries with it, if persistently used, danger of hypersensitization toward it.

9. **The control of acute attacks of asthma:** In very mild cases, inhalation of the smoke from the burning of powdered stramonium leaves is quite satisfactory. If not, then one of the ephedrine or phenobarbital tablets may prove effective. In event that the situation seems to be getting out of hand, our patients have in their medicine chests, at all times, rectal suppositories containing 500 mgm. aminophyllin. In all but severe attacks, this is adequate.

PROGNOSIS

In conclusion, our patients are advised that the amount of relief that will be experienced during the next hay fever season will depend upon the amount of tolerance which they have gained and the amount of exposure to which they happen to be subjected. We believe there is a quantitative relationship between the amount of pollen which is breathed in and the degree of tolerance which has been gained by the injections. This tolerance will be inadequate, adequate, or more than adequate and the relief will be according.

There may be no symptoms at all, or if the pollen crop is unusually rich, there may be a few days of trouble at the peak of the season when the concentration of the pollen in the air is heaviest. At such times, symptoms may develop for a few hours or a day and then the amount of pollen will, of course, return to a point below the tolerance of the patient and the symptoms will disappear.

We make it a rule to carry our patients on a perennial schedule of 0.25 mgm. given once

every 3 weeks between seasons. We raise this according to the schedule in Table 1 to 0.75 mgm. just before the next season. We continue this year in and year out until the patient has two consecutive years with no symptoms and one month after the last injection in the autumn, dry pollen rubbed into a scratch wet with a dilute alkaline saline solution gives no reaction. In this event, the patient is discharged with instruction that he is to return if symptoms recur, but with the assurance that the chances are better than 990 out of 1000 he will never come back or have trouble again.

A LIST OF PLANTS CAUSING POLLINOSIS IN OHIO

TREES*

Pine Family
1. Pine—73

Maple Family
2. Sugar Maple—1382 Acer Saccharum Marsh
3. Boxelder—1387 Acer Negundo L.

Plane Family
4. Sycamore—1397 Platanus occidentalis L.

Elm Family
5. White Elm—1398 Ulmus americana L.

Beech Family
6. American Beech—1417 Fagus grandifolia Ehrh.
7. White Oak—1423 Quercus alba L.

Birch Family
8. Blue-beech—1434 Carpinus caroliniana Walt.

Walnut Family
9. Shagbark Hickory—1450 Hicoria ovata
10. Black Walnut—1452 Juglans nigra L.

Willow Family
11. Cottonwood—1461 Populus deltoides Marsh

Olive Family
12. White Ash—1620 Fraxinus americana L.

GRASSES*

Poatae

Fescue-Grass Subtribe
13. Tall Fescue-grass—338 Festuca elatior L.
14. Annual Meadow-grass 356 Poa annua L.
15. Kentucky Blue-grass—362 Poa pratensis L.
16. Orchard-grass—365 Dactylis glomerata L.

Oats Subtribe
17. Common Oats—389 Avena sativa L.
18. Velvet-grass—393 Nothoholcus lanatus L.

Bent-Grass Tribe
19. Red-top—404 Agrostis alba L.
20. Timothy—415 Phleum pratense L.

Canary-Grass Tribe
21. Sweet Vernal-grass—435 Anthoxanthum odoratum L.

Barley Tribe
22. Rye—443 Secale Cereale L.
23. Virginia Wild-rye—444 Elymus virginicus L.
24. Common Barley—449 Hordeum vulgare L.

Panic-Grass Tribe
25. Small Crab-grass—501 Syntherisma ischaemum (Schreb) Nash
26. Common Barnyard-grass —503 Echinochloa crus-galli L.
27. Verticillate Foxtail-grass 509 Chaetochloa verticillata L.

Beard-Grass Tribe

Maize Subtribe
28. Indian Corn—524 Zea mays

WEEDS*

Ragweed Group
29. Cocklebur. Pennsylvania —2024 Xanthium pennsylvanicum Wallr.
30. Ragweed, Giant—2027 Ambrosia trifida L.
31. Ragweed, Western—2028 Ambrosia psylostachya DC.
32. Ragweed, Short (Roman Ragweed)—2029 Ambrosia elatior L.
33. Marsh elder, true Iva ciliata
34. Marsh elder, Burweed Iva xanthifolia

Chenopodiaceae

Goosefoot Family
35. Chenopodium album L. —1060 Lamb's-quarter
36. Chenopodium ambrosioides L.—1069 Mexican Tea

Amaranthaceae

Amaranth Family
37. Pigweed, Rough—1051 Amaranthus retroflexus L.
38. Tubercled Water-hemp —1056 Acnida tuberculata Moq

Polygonaceae

Buckwheat Family
39. Yellow (or curled) Dock —1101 Rumex crispus L.
40. Sheep Sorrel—1102 Rumex acetosella L.

Cannabinaceae

Hemp Family
41. Hemp—1407 Cannabis sativa L.

Plantaginaceae

Plantain Family
42. Plantain, Major (common)—1883 Plantago major L.
43. Plantain, Ribgrass—1884 Plantago lanceolata L.

Anthemideae

Chamomile Tribe
44. Annual Wormwood—2228 Artemisia annua L.

* Number refers to Schaffner's Vascular Plants of Ohio, 1932.

BACTERIAL SKIN TESTS FOR ALLERGY (INTRACUTANEOUS INJECTIONS)

Streptococcus viridans	Bordet's bacillus
Streptococcus hemolyticus	Acne bacillus
Crowe's rheumatoid streptococcus	Pfeiffer's bacillus
Cecil's streptococcus rheumatoid arthritis	Mucosis Capsulatus
Staphylococcus albus	Brucella No. 9
Staphylococcus aureus	Abortus melitensis
Staphylococcus hemolyticus	Abortus suis
Micrococcus catarrhalis	Tuberculin No. 1 PPD
Micrococcus pharyngitis siccus	Tuberculin control No. 1 PPD
Pneumococcus	Tuberculin No. 2 PPD
Friedlander's bacillus	Tuberculin control No. 2 PPD
Bacillus coli	

Cardiac Arrest

Prevention of cardiac arrest, the most important aspect of all, has been given attention by most authors, and their suggestions have included the necessity of maintaining an adequate airway, preventing undue anxiety of the patient, avoiding excessive accumulation of carbon dioxide, diminishing the number of anesthetic agents administered during one operation and a better maintenance of blood volume.

We would urge a more frequent reliance in preoperative medication on an old, simple and pharmacologically sound drug, atropine sulfate. By interfering with the action of acetylcholine on the patterned cell receptor or that patch of the cell surface where it would ordinarily be absorbed, atropine prevents the rare lethal vagal reflex from taking effect through its release of acetylcholine. Particularly should it be used before procedures likely to elicit a vago-vagal reflex, such as during an angio-cardiogram, during downward traction on the stomach, insertion of an endotracheal tube or before a major positional change, to mention but a few examples. Where vagal tone is increased, as in the obstructive jaundiced patient, larger doses of atropine should be used. Too often atropine is given preoperatively but in insufficient amounts and too long before it is needed.—Hugh E. Stephenson, Jr., M. D., Columbia, Mo.: *Missouri Med.*, 51:370, May, 1954.

Congenital Heart Disease

A Pediatric Review

ROBERT A. LYON, M. D.

COARCTATION OF THE AORTA

IN an excellent review of coarctation of the aorta, Gross[1] has summarized the diagnostic features of the disease and various phases of treatment and prognosis. One of the most important aspects of diagnosis was related to early detection of the lesion in infancy. In some of these young patients, coarctation of the aorta caused cardiac failure and required early treatment.

At this age many of the typical diagnostic signs were absent and a great deal of reliance had to be placed upon elevations of arterial blood pressure of the arms and lower than normal levels in the legs. The pulsations of femoral arteries in the groin were diminished in intensity or absent. Murmurs were occasionally present but of no diagnostic value. The typical changes occurring in roentgenograms of adults, such as erosion of the lower edges of the ribs from enlarged intercostal vessels which are providing collateral circulation, were entirely absent in infancy and usually did not appear until late childhood or adolescence. Rarely did electrocardiograms show changes typical of coarctation, although occasionally left ventricular hypertrophy was detected.

The diagnostic test which provided the greatest assistance in making an accurate diagnosis was the retrograde injection of an opaque substance into a large artery. By this means, the aorta was visualized and the location and extent of the constriction could be clearly delineated.

Operation for the removal of the constriction can be carried out in infants when it seems to be a life saving measure, but Gross emphasized the fact that infants who survived the first year of life were apt to make satisfactory progress during the remainder of the childhood years. The optimum age for operation, in his opinion, was from 10 to 20 years. After that period of life, complications arising from cardiac strain and hypertension were apt to produce irreversible changes which made operation more difficult and the prognosis less favorable.

PATENT DUCTUS ARTERIOSUS

Other congenital heart lesions which received a good deal of attention during the past year were those characterized by cardiac enlargement, prominence of the pulmonary artery and excessive blood flow through the lungs, as detected by heavy vascular shadows in roentgenograms of the chest. Cyanosis is absent but the patients, especially in infancy, may show various degrees of circulatory failure.

Most conditions of this sort used to be diagnosed as defects of the auricular or ventricular septum and no treatment was available except supportive measures to allay symptoms. Recently many of these patients have been found to have patent ductus arteriosus as the sole lesion and have been completely cured by surgical treatment.

Among 25 such patients observed by Ferencz, Johnson and Goldbloom,[2] eight were found to have patent ductus; ten had patency of the interventricular septum and the others had more rare lesions.

A series of 16 infants with patent ductus arteriosus who were less than 18 months of age were reported by Adams and his co-workers.[3] Most of the patients were underweight but there were no pathognomic symptoms and the murmurs were atypical of the classical machinery sounds of the open ductus. Hypertension with a wider than normal pulse pressure was often present, as were radiologic findings of enlargement of the heart, pulmonary artery and its branches. In order to be certain of the diagnosis in these young infants, catheterization or angiocardiography often had to be employed.

PULMONARY STENOSIS

Isolated stenosis of the pulmonary artery is a condition rarely recognized ten years ago either clinically or pathologically, but is now found with considerable frequency. The importance of the lesion is magnified by the fact that it can be corrected surgically with great benefit to the patient. Gibson and his colleagues[4] have reviewed recently their experience with 45 children with this condition. Most of the patients had few symptoms in infancy but developed cyanosis, tachycardia and dyspnea at various ages of childhood. The heart was usually enlarged and a systolic thrill and murmur were

The Author

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Submitted May 20, 1954.

prominent in the second and third left intercostal spaces.

Roentgenograms showed the cardiac enlargement, but of greatest importance was the prominence of the pulmonary artery and a diminution of the vascular markings in the lung fields. Electrocardiograms demonstrated tall, peaked P waves and signs of right ventricular strain. When doubt of the diagnosis remained, angiocardiography and catheterization of the heart furnished conclusive evidence by eliminating the possibility of overriding of the aorta and by proving an increase of pressure in the right ventricle and a lower than normal presure in the pulmonary artery.

Since obstruction of the pulmonary artery is usually at the valvular area, surgical treatment of inserting a knife through the right ventricular wall and incising the pulmonary valve is highly successful in producing complete relief of symptoms.

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Salt Restriction Difficulties

Salt restriction may result in three general difficulties. Occasionally in patients having so-called salt-losing nephritis, salt is lost excessively in the urine. If restriction is also carried out in the diet, marked dehydration may take place and the results of sodium lack, may occur.

Secondly, a patient may take additional sodium despite his dietary instructions. He may unconsciously get salt in his diet. This may happen if his instructions have not been adequate and he takes sodium bicarbonate or some other sodium containing substances which he does not consider in the category of salt. He may also take foods with much salt in them not realizing their content. Due to the unpalatability of the diet when it is low in salt the patient may cheat, by taking salt to make the diet more palatable. Both of these situations can be detected by checking the amount of salt in the twenty-four hour specimen of urine.

Thirdly, the poor food intake from unpalatable low sodium diets may produce anorexia and a continuing train of symptoms related to malnutrition resulting in additional refractoriness.—William A. Sodeman, M. D., Columbia, Mo.: *Missouri Med.*, 51:379, May, 1954.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Hermetic—To seal something hermetically now means an air tight sealing by fusion or by means of a mercury seal. The Greek god Hermes served as the messenger of the Olympian Gods, conducting souls to Hades. His counterpart in Roman mythology was the god Mercury. Both Hermes and Mercury were revered by the ancient alchemists and Hermes was the reputed father of alchemy. Hence the term came to be used by the alchemists in connection with the sealing of flasks and vials, especially when they were sealed with mercury.

Haggard—This term came into English from the French word "hagard" meaning wild or strange. This in turn is derived from the Mid-Latin word "haga," or hedge, plus the ending "ard" which acts as an intensive. The term was originally applied to a wild hedge or woods and then to an ill kept or badly tended hedge. Hence by analogy it came to mean a wild or strange appearance and especially having a gaunt appearance with sunken eyes.

Symposium—Little change has occurred in this gathering for mutual discussion since the ancient Greek days of Plato's "sumposium." However these gatherings were originally for the much gayer purpose of being a drinking party, and the term is derived from the Greek words "sun," or together, and "posis"—to drink.

Ecchymosis—This term has descended to us unchanged from the days of Hippocrates who used the word to designate the extravasation of blood beneath the skin from the bursting of a small blood vessel. This word is composed of the Greek prefix "ek," or out of, and "chumos" or juice, from "chuo," I pour out. Hence the word literally means to pour out juice or shed blood.

Santonin—This drug which is used for its poisonous action on intestinal parasites is the anhydride of santoninic acid. This is obtained from the unexpanded flower heads of several species of artemisia, which is also known as Levant wormwood. The Greeks called this plant "santonikon" because it was found in the country of the Santones, a people who lived in ancient Gaul.

Sarsaparilla—This substance is obtained from the dried roots of various species of smilax and was used in the treatment of chronic rheumatism, skin diseases and syphilis. The compound syrup is used as a vehicle for various drugs. The term "sarsaparilla" comes from the Spanish name of this plant which is "zarzaparilla" and literally means a small bramble vine. The term is composed of the Spanish words "zarza," or bramble, and "parilla," a small vine.

—Harry Wain, M. D., Mansfield, Ohio.

Proceedings of the Ohio Society of Pathologists

Reported by CHARLES L. BLUMSTEIN, M. D., Lima, Ohio

THE mid-winter meeting of the Ohio Society of Pathologists was held at the department of pathology, Ohio State University College of Medicine in the Old Starling Loving Hospital, Columbus, Ohio, on Saturday, January 30, 1954, at 2:00 p. m. The meeting was well attended and enlivened by pertinent discussion especially produced by the provocative topics of discussion and the diagnoses presented at the slide library seminar. Dr. Emmerich von Haam acted as moderator.

SCIENTIFIC PROGRAM

The first paper was presented by Dr. J. M. Bloodworth, Jr. His subject was "The Catechol Amine Content of The Human Heart." The analysis of various organs for catechol amines (e. g. epinephrine and norepinephrine) were determined in patients who died of various conditions other than sudden death (coroner's autopsies). Raab had observed in routine toxicological studies that catechol amines are elevated in patients expiring in cardiac arrest and sudden death.

These observations by Raab were confirmed in a series of studies by Dr. Bloodworth. Rabbit experiments were performed by injecting epinephrine in animals and assaying muscle, liver, spleen, kidneys, etc. Bio-assay method of Shaw was used by incubation with strong alkali and purification by absorption with aluminum hydroxide. Reduction properties were measured as aceto-amino acid. All organs revealed increase of catechol amines following epinephrine injections. Determinations were performed in patients following adrenalectomy and sympathectomy. These all revealed no change in catechol amine content of muscle and organs. The mean average or median of catechol amine content of the human heart is given as 0.24± micrograms.

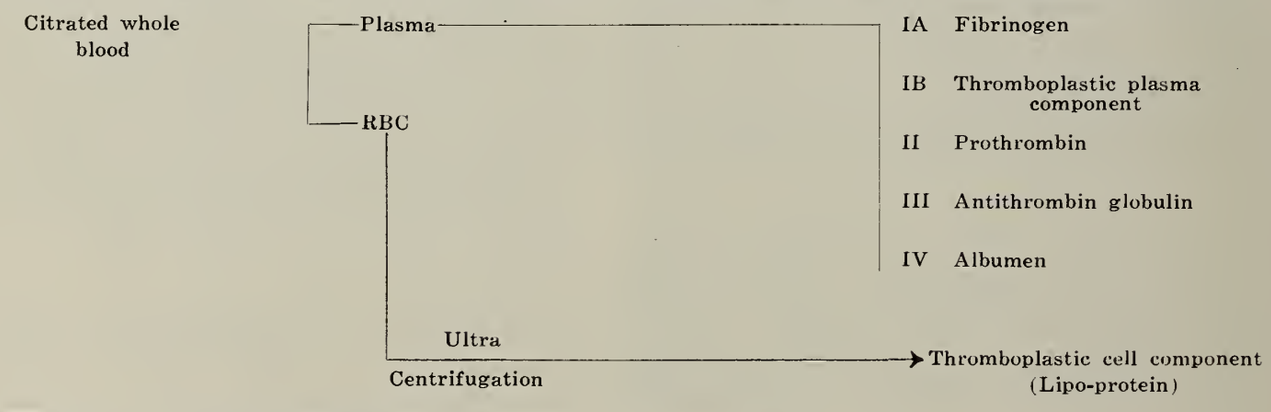
Additional work was carried out by injecting adrenalin® intravenously into patients just prior to death and also in patients in postmortem state. The average catechol amine content in the heart of patients injected prior to death revealed results ranging from 0.37 to 2.01 micrograms. The series of patients injected post mortem revealed elevated content in patients in uremia, shock, carcinoma, diabetes mellitus. Low values were obtained in patients with hypertensive cardiovascular disease.

PLASMA FACTORS IN PANCREATITIS

The second paper was presented by Dr. G. Y. Shinowara, associate professor of clinical pathology at Ohio State University School of Medicine. It was entitled "Plasma Coagulation Factors in Acute Pancreatitis." The fractions of citrated whole blood were separated via ultracentrifugation and biochemical determinations according to the accompanying plan below.

Observations in several cases of pancreatic diseases at operations and at autopsies showed thrombosis, which was especially noted in carcinoma of the pancreas. Plasma factors were studied in pancreatitis especially experimental pancreatitis (in dogs) by tying off both pancreatic ducts. The serum amylase on dogs was

SCHEME FOR SEPARATION OF WHOLE BLOOD



The following methods of thrombin formation were outlined:

With Tissue Injury: Prothrombin + Thromboplastin + Ca ⟶ Thrombin.

Without Tissue Injury: Prothrombin + { Thromboplastic plasma component, Thromboplastic cell component } + Ca ⟶ Thrombin.

Submitted May 7, 1954.

increased 10 times higher than noted in human beings. The thromboplastic plasma component (TPC) was elevated 20 fold. It was also noted that fibrinogen determinations for dogs and human beings were identical. Observations in these experiments with dogs showed that serum amylase was increased three times normal and remained high for duration of one week. The thromboplastic plasma component (factor deficient in hemophilia) took one week to return to normal. Fibrinogen was elevated to twice normal value and took two weeks to return to normal. In a control group there was no elevation of TPC or fibrinogen.

Six patients were observed during seven attacks of acute pancreatitis. These patients showed elevated serum amylase values of 1400 Somogy units on admission, but the TPC was increased 10 fold over normal values and occurred two to three days after the serum amylase rise. Fibrinogen was also elevated but prothrombin was unchanged.

It was also suggested that the blood of a patient in acute pancreatitis attack would be ideal for transfusion (provided it was compatible) in a hemophiliac patient. It is not known whether TPC is in the alpha, beta or gamma fractions of the globulin of the blood. However, the author of the paper suggests that TPC is a half kinase requiring a lipo-protein for activation.

NEOPLASIA IN THE PARAKEET

The third paper was given by Dr. Hans G. Schlumberger, professor of pathology at Ohio State University School of Medicine. He presented "Neoplasia in The Parakeet." In response to advertisements for tumor-bearing parakeets, approximately 400 of these birds (melopsittacus undulatus) were obtained from breeders throughout the U. S. A. Of the 400 birds, 150 of them bore one or more neoplasms. Most numerous were the 68 chromophobe adenomas and carcinomas of the pituitary. Malignancy was manifested by invasion of the brain, meninges, optic nerves, calvarium, or orbits and rarely by metastasis to the kidneys and liver. Renal papillary adenocarcinomas were encountered in 15 birds. Sarcomas of the skin were found in another 13. However, epidermoid carcinoma was seen only once. Large goiters were present in 15 birds, 13 of which were females. The livers and spleens of 14 birds were the site of reticulum cell and fibro-sarcomas. Other locations of tumors were periosteum, bone, ovary, peritoneum, thymus (usually sarcomas).

TRAINING OF MEDICAL TECHNOLOGISTS

The fourth paper was presented by Dr. Harry L. Reinhart, professor of clinical pathology at Ohio State University School of Medicine. His paper was entitled "Training of Medical Technologists at Ohio State University."

The training of medical technologists at Ohio State University is in the curriculum of the College of Arts and Sciences. The curriculum requires four years with the last 52 weeks in the laboratories of the University Hospital, leading to the degree of Bachelor of Science with a major in medical technology. Graduates of approved colleges and universities with a major in chemistry and a minor in biology or vice versa, are accepted for the vocational training period in University Hospital. A graduate program leading to a Master of Science degree in pathology is offered to qualified students.

Although the principal emphasis in the hospital training is upon technical mastery of standard laboratory procedures, a well rounded educational program of University standards under direct supervision of the staff of the department of pathology is presented. The purpose is adequate technical and educational training of the student and not the use of student services for the benefit of laboratory or hospital.

Discussion followed each of the above presentations and was guided by Dr. Emmerich von Haam, professor of pathology at Ohio State University.

* * *

Abstracts of Cases from Slide Seminar

Moderator: Dr. Emmerich von Haam
Columbus, Ohio

Abstracts of histories and clinical findings were mailed to all members prior to this meeting for study and final diagnoses represent majority opinion of the Society.

Case 498. Presented by Dr. A. S. Thompson Brown General Hospital, V. A. Center Dayton, Ohio.

The biopsy has been taken from the deltoid muscle of a 34 year old colored male who had complained of generalized muscular weakness for the past seven months. The physical examination showed a helpless young Negro who was unable to turn his head without assistance. The lower and upper extremities bilaterally showed evidence of muscular atrophy. The neurological examination suggested muscular dystrophy of the atrophic type or a Guillain-Barre syndrome. The patient developed respiratory difficulties and died. The central nervous system autopsy findings were completely negative. The disease was primary in voluntary muscles (including the diaphragm) unconnected with central nervous system. The heart was also involved with a plasma cell and histiocytic cellular proliferation. The striated muscle fibers per se revealed endomysium proliferation accompanied by vacuolization and hyalinization. Creatinuria was elevated.

Diagnosis: *Chronic polymyositis.*

Case 499. Presented by Dr. A. S. Thompson, Brown General Hospital, V. A. Center, Dayton, Ohio.

The section was taken from the kidney of a 70 year old white male who complained of enlargement of the liver with nausea, loss of weight and severe pain in the back of four months' duration. Physical examination showed a

markedly enlarged liver and a non-movable palpable mass in the left upper quadrant of the abdomen. A liver biopsy revealed a metastatic carcinoma. The patient went downhill rapidly and died. At autopsy a large tumor was found in the left kidney region with extensive local and distant metastasis.

Microscopic sections revealed hyalinized glomeruli with increased stroma (of mixed tumor type) showing embryonic cartilage cells. The malignant cells were metastatic to lymph nodes and liver surrounded by scanty cytoplasm. Opposite kidney was negative.

Diagnosis: *Renal carcinoma with chondroid metaplasia.*

Case 500. Presented by Dr. J. M. B. Bloodworth, Jr., department of pathology, Ohio State University School of Medicine.

The section has been taken from a large bladder tumor in a 70 year old white male who complained of frequency and incontinence for the past 1½ years. Catheterization revealed an impassable obstruction of the bladder outlet. On laparotomy a large diverticulum was found which was filled with a hard tumor mass. Eleven days after cystostomy a resection of the bladder diverticulum containing the tumor was done. The patient was discharged and is doing well. A year prior to this admission a transurethral prostatic resection was done and the report of tissue removed was benign hypertrophy of the prostate. Intravenous pyelography was normal. No metastasis in bone was found upon x-ray examination. His blood urea nitrogen was 20 mg. per 100 ml. Testes normal.

Diagnosis: *Carcinoma of urinary bladder with osteochondral metaplasia.*

Case 501. Presented by Dr. Emmerich von Haam, professor of pathology, Ohio State University School of Medicine.

The section has been taken from a tumor of the blade of the right scapula in a 64 year old man who complained of gradually increasing pain in this area of one month's duration. Examination showed a slight swelling below the midportion of the spine, which was firm, non-fluctuant and appeared firmly attached to the bone. At surgery a large tumor was found beneath the deep fascia and muscle which appeared to arise from the interspinous fossa of the scapula and was partially bridged by the spinous process.

As a result of biopsy complete removal of the right scapula was performed and the head of the humerus wired to the clavicle. Extensive investigation revealed no other tumor present in the patient. There was no evidence of previous injury. A complete skeletal x-ray survey revealed no other tumor. It was thought that this might represent a metastatic lesion, but the patient revealed no other complaints except painful mass in the shoulder.

Diagnosis: *Squamous carcinoma in bone.*

Case 502. Presented by Dr. J. B. McMillan, department of pathology, Ohio State University School of Medicine.

The section has been taken from the liver and a lymph node of a 57 year old colored female whose uterus had been removed one year previously for tumor. The patient received external x-ray therapy but developed swelling of the abdomen with nausea, vomiting and anorexia. The physical examination showed a distended abdomen filled with fluid with numerous large and small tumor masses palpable. The pelvis was filled with tumor extending to both lateral walls. The patient went gradually downhill and died with a rising blood urea nitrogen. At autopsy metastasis was found in the spleen, liver, adrenals, intestines, peritoneum and in all pelvic, retro-peritoneal, mesenteric and cervical lymph nodes.

Diagnosis: *Carcino-sarcoma (mixed mesodermal tumor).*

Case 503. Presented by Dr. Sylvia Bubis, department of pathology, Ohio State University School of Medicine.

The section has been taken from the adrenal gland of a white female infant who was born to a 31 year old healthy primigravida in the thirty-second week of pregnancy. The pregnancy had been uneventful until the membranes ruptured in the 30th week and the baby was delivered after a 17 hour labor by low forceps. The baby was found to have a large ruptured omphalocele and died ten minutes after birth.

The adrenals were of the usual size, shape and position. Microscopic examination of the adrenals showed large nuclei and increased surrounding cytoplasm forming isolated cell groups. Inclusions were evident in both the nucleus and cytoplasm. No evidence of inclusion bodies in cells of other organs. Dr. Edith Potter of University of Chicago has reported these findings in 50 per cent of children less than two years of age. It is not a pathological finding as far as can be determined by reports in the literature. Drs. Craig and Landing also confirm these findings in their series of cases.

Diagnosis: *Cytomegaly of adrenals.*

Case 504. Presented by Dr. Melvin Oosting, Miami Valley Hospital, Dayton, Ohio.

The section has been taken from the heart of a two day old white female infant which was delivered in normal delivery after an eight months' gestation. The mother had gone through a normal period of pregnancy except for a severe case of "flu" five months prior to delivery. The child was born with club feet and did poorly after delivery. She died two days later in spite of all therapeutic measures.

Microscopic sections of the heart revealed large areas of fibrosis and calcification. No inclusion bodies noted in cells of the heart muscle or other organs.

Diagnosis: *Fetal chronic myocarditis with calcific deposition.*

Case 505. Presented by Dr. Robert E. Wybel, Grant Hospital, Columbus, Ohio.

The section has been taken from the thyroid of a 42 year old white female who complained of a rapid heart beat, enlargement of the neck, protruding eyes, tiredness and nervousness of two months' duration. On x-ray the gland appeared three times normal size. The patient showed exophthalmos, a pulse of 108/min and a basal metabolic rate of plus 22. A thyroidectomy was performed and at operation the surgeon encountered a fibrotic area on one edge of a lateral lobe of the thyroid which he considered to represent a scar. The removed gland weighed 24 gms.; showed a meaty pinkish-tan parenchyma with a faint lobular pattern and a semicircular firm tan colored fibrotic area on lateral surface of the right lobe.

Microscopic findings are frond like epithelial infoldings accompanied by a uniform hyalinized

fibrous tissue matrix. This lesion is seldom suspected at surgery and does not metastasize. However, it does recur locally if not completely removed.

Diagnosis: *Non-encapsulated sclerosing tumor of the thyroid (Papillary adeno-carcinoma).*

Case 506. Presented by Dr. Christie Davis, Columbus, Ohio.

The section has been taken from the uterus of a 50 year old white woman who complained of pain in the abdomen with spotty hemorrhage for the past six months. Her last normal menstruation period was three years ago. Physical examination showed a greatly enlarged uterus There was profuse hemorrhagic vaginal discharge. The surgical specimen showed a completely extirpated uterus which measured 106 mm. in largest diameter and showed marked thickening of the uterine wall. The endometrial cavity was distended and filled with blood. It contained a papillomatous, partially necrotic tumor mass which covered the entire surface of the endometrium. The adnexae showed numerous adhesions compatible with chronic pelvic inflammatory disease.

Microscopic findings revealed two types of epithelial malignancy; one type made up uniform sheets of abnormal epithelial cells surrounded by paucity of light staining cytoplasm; the other type showed epithelial cells forming infoldings of papillary type. The sections of cervix were free of tumor.

Diagnosis: *Adeno-carcinoma, undifferentiated and papillary types of the uterus.*

Case 507. Presented by Dr. Horace B. Davidson, Columbus, Ohio.

The section has been taken from the second finger of the left hand of a 26 year old male, which was amputated at the proximal phalangeal joint. Longitudinal sectioning disclosed a tumor lying near the proximal end of this phalanx. This tumor represented the third recurrence within one year and at the time of amputation measured 1 cm. in diameter.

Microscopic findings showed large round or polyhedral cells some of them with clear cytoplasm and resembling cartilage cells. These cells showed a loose pattern with foci of early calcification. Beginning necrosis is apparent accompanied by rarefied zones. Other fields show densely packed cells of the same tumor formation surrounded by hemorrhage, hyaline degeneration and multinucleated giant cells.

Diagnosis: *Chondroblastoma (Codman tumor).*

Case 508. Presented by Dr. Mel Davis, Columbus, Ohio.

The section has been taken from a lymph node of a 64 year old white male who had been treated extensively with arsenic for psoriasis. He developed multiple keratotic lesions not confined to palmar and plantar surfaces. Three years ago a squamous cell carcinoma was removed from his left heel. In the last month the patient developed elevated bluish red ulcerated lesions and enlargement of an inguinal lymph node. A section of this node was taken for biopsy. The patient died shortly afterwards and showed skin lesions of the soft and keratotic types and extensive tumor metastasis to lymph nodes, bone marrow and liver.

Diagnosis: *Epidermal carcinoma, differentiated and undifferentiated, metastatic to inguinal lymph node.*

Case 509. Presented by Dr. Hans Schlumberger, professor of pathology of Ohio State University School of Medicine.

The slide has been taken from a 69 year old white male who had been under observation for several years with a diagnosis of osteitis deformans. Three months before the present admission he became aware of a swelling over the left parietal bone. The mass increased rapidly in size and roentgenograms showed irregular density of the bone in this region. At operation an oval piece of involved bone 5 cm. in its greatest diameter was removed. A circular mammillated 4 cm. area projected 1.5 cm. above the outer table and 1.0 cm. below the inner table. On bisecting the specimen some portions were found to be quite porous and soft, others were dense and hard.

Microscopic findings revealed a typical mosaic trabeculated osseous pattern with osteoblastic proliferation and occasional osteoclast seen in the field. Other portions revealed a marked stromal proliferation of spindle shaped cells accompanied by occasional giant cells of abnormal character. Necrosis and marked hyalinization are apparent.

Diagnosis: *Osteogenic sarcoma in osteitis deformans (Paget's disease).*

Case 510. Presented by Dr. Hans Schlumberger, professor of pathology of Ohio State University School of Medicine.

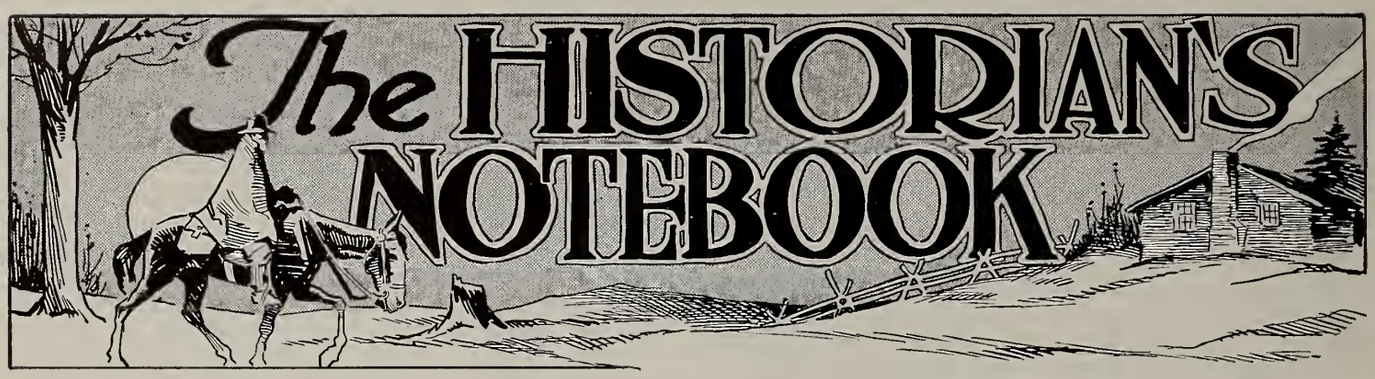
A graduate zoology student interested in parasitology found a dead muskrat along the Olentangy River on the Ohio State University campus. He performed an autopsy upon the animal and found that a part of the liver was replaced by a roughly spherical 4 cm. mass. The latter was friable, grayish pink and contained several cysts in which were tapeworm larvae. These were identified as Taenia crassicollis (Cysticercus fasciolaris). The mass from the liver was taken to the department of pathology for examination.

Microscopic examination revealed an undifferentiated stromal cellular proliferation of spindle shaped cells with elongated and bizarre shaped dark staining nuclei devoid of encapsulation. This is an unique case of animal in nature developing malignancy with an accompanying etiological factor (worm infestation). This has also been duplicated experimentally in the white rat.

Diagnosis: *Fibrosarcoma of the liver following worm infestation.*

Mercurial Diuretics

Without regard to the pros and cons of action of the mercurial drugs, one may assume that the mercurials are effective diuretics through suppression of tubular absorption of electrolytes, sodium, chloride, potassium, and others. The concentration of sodium and chloride in body fluids determines, in part, the effectiveness of this action. Activity of the drug would produce, depending upon its relative effectiveness from person to person, a great or a small loss of chloride. Variation in sodium output would also occur. Depending upon this effectiveness, along with fluctuations in intake of sodium and chloride, a number of individual variations in the electrolyte pattern may appear.—William A. Sodeman, M. D., Columbia, Mo.: *Missouri Med.*, 51:379, May, 1954.



Side Lights on the History of Circumcision

ROBERT CONARD, M. D.

CIRCUMCISION, a surgical operation practiced since the earliest times, has a most obscure origin. The Phoenicians, the Egyptians and the Hebrews, the three peoples whose history, monuments and other relics are of the greatest age of any yet discovered are claimed by various antiquarians to have priority in this custom as a tribal observance or as a religious ritual.

EARLIEST TRACES

The Phoenician author Sanchroniston, 1364 B.C. says that Kronos, a king of Phoenicia, first introduced it among that people and the Egyptians.

Herodotus, however, in his *Account of Egypt*, says, "Of the Egyptians and the Ethiopians, I am not able to say which learnt it from the other, for undoubtedly it is a most ancient custom." He says further, "The Egyptians, the Ethiopians and the Colchians alone of all the races of men have practiced circumcision from the first. The Egyptians and the Syrians say that they have learned it lately from the Colchians."

The Hebrew claim to priority is based on *Genesis 17:10*, when God commanded Abraham that circumcision of every male child on the eighth day after birth should be done as a sign of the covenant with Abraham and his descendants as his chosen people forever.

The Phoenician origin cannot be proven since there are relatively few remaining traces of that once powerful race. The Egyptians, however, have left a rich store of relics of their life and customs and from these much has been learned about this procedure, its practice, its significance and its antiquity.

Egyptian mythology attributes the origin of phallic worship, of which circumcision is perhaps one phase, to the goddess Isis. After the death of her brother-husband Osiris, murdered by Typhon, Isis found his body floating in the river and hid it, but it was discovered by the still vengeful murderer, cut into some 28 pieces, and these pieces scattered all over Egypt. Isis, after long search succeeded in gathering up and embalming all the parts except the phallus, which unfortunately had been eaten by fish.

Egyptian monuments provide evidence that circumcision was practiced in that country as early as the fourth dynasty. In the tomb of Sakkaris at Karnak a bas relief showing a priest or physician performing circumcision on a newborn infant dates back some 4500 years. Well preserved mummies of later dates show that circumcision was the rule in the time of the Pharaohs.

A MARK OF PRIEST, NOBLE AND WARRIOR

Originally, in Egypt the custom was limited to the priesthood who were not only circumcised but shaved their heads and their whole bodies as a mark of purity. Later the nobility and the warrior caste adopted the custom. To be uncircumcised was evidence of belonging to the lower classes, hence the Biblical reference to "the reproach of Egypt." *(Joshua 5:9)*

When Pythagoras visited Egypt in order to be initiated into the mysteries of the Egyptian priesthood he was required to be circumcised before he could study geometry and astronomy, as he otherwise would not be eligible. Seven hundred years later, the Christian Father Origen, visiting Egypt for the same purpose had to submit to the same painful and humiliating

The Author

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Submitted May 14, 1954.

initiation. He must have been favorably impressed by the procedure, as there is a record of a spirited argument in favor of it, in which he opposed the Greek Stoics, who were against it.

The Egyptian warrior class showed their pride in this mark of their caste on at least one recorded occasion. At one time 200,000 Egyptian regular troops rebelled on account of preference being shown by Psammetisch (25th Dynasty, 594-589 B. C.). These regulars deserted, marching towards Ethiopia. Psammetisch pursued and overtook them. When he tried to persuade them to return they threatened him, "striking him with shield and spear" and, presumably to show that they were proper members of the military caste, exhibited their properly circumcised parts.

As evidence that circumcision was not generally practiced by other tribes in that region, Autenrieth in 1829 described the tomb of Osymandias at Thebes, which had been described previously by Diodorus Siculus and by the French scientists who accompanied Napoleon when he conquered Egypt. On this monument were shown rows of captives, who according to their clothing and weapons were of a tribe different from the ancient Egyptians, with heaps of their severed hands being tallied by scribes, on papyrus rolls. At the end of the last row of captives, together with the hands were a pile of severed whole male genitals, none of which, according to the French scientists, showed any signs of circumcision.

THE COVENANT WITH ABRAHAM

As to the origin of circumcision among the Hebrew race, the covenant with Abraham as previously noted and the command to practice this as a sign, was given when Abraham was 99 years old. Previously at age 75, by divine command, the patriarch had made a trip to Egypt and Phoenicia, where he must have remained a considerable time since it is recorded that when he left Egypt at the urgent insistence of Pharaoh he was "very rich in cattle, silver and gold." It may be assumed that during this period in Egypt he learned of the practice of circumcision as a mark of superior caste and learned how it was done, so when the command was given him to establish the rite in his tribe he was given no technical details as to its performance.

As we have seen that early Egyptian monuments confirm that the custom had prevailed in that region for at least 1500 years, it probably was known to the Hebrews but not adopted by them until the time of Abraham.

THE TECHNIQUE

An elaborate religious ritual and a special technique of performing the operation persisted through the centuries as a mark of the Jewish faith and evidence of acceptance. Christian baptism is analogous to this and was substituted for it under the influence of St. Paul.

The technique differed from that of other peoples in that it required the separation of the inner and outer layers of the prepuce. This was done by tearing by means of the sharpened thumb nails of the operator. This was apparently for the purpose of preventing later adhesions to the glans. Unless done in this exact manner the rite was not considered valid and had to be repeated. There was also a provision for spraying wine upon the wound from the mouth of the operator and suction of the wound by the mouth of the operator. Maimonides stressed this latter unpleasant part of the ceremony as important to prevent hemorrhage. The great authority of this renowned physician kept this repulsive part of the rite in vogue for centuries, until comparatively recent times.

The strict observance of the rule that circumcision should be done on the eighth day follows the original command and is also related to the fact that both mother and child were considered unclean for seven days after the birth. *(Leviticus 12:3)*

SIGNIFICANCE OF THE HEBREW RITUAL

The psychiatrists have ingenious explanations of this ceremony. Blood letting and blood exchange as a sign of sealing covenants and of adoption as a tribal brother is an ancient custom with many tribes in all parts of the world. Two men open their veins and suck each other's blood, a custom said to be known still in Lebanon and some parts of Arabia.

The newborn child, say some of these psychiatrists, is an outsider and has to be adopted formally into the family. According to this view the child, a stranger, an interloper, is thus adopted, overcoming the instinctive hostility of the father. The wine is regarded as symbolic of blood exchange. Another practice in ritual circumcision mentioned as having a symbolic meaning is "the chair of Elijah," a vacant chair required to be placed at the scene of the ceremony.

Elijah *(I Kings 19:24)* championed the covenant when the Children of Israel had forsaken it, and thus had a special role in the ceremony. It is suggested by some in discussing the symbolism of the rite that the story of Elijah's resuscitation of the Widow's son may mean that the symbolic presence of the prophet refers to the possible need for first aid should there be any complication at the operation, threatening the life of the child.

The *Old Testament* has many little stories illustrating the significance of this procedure in early Hebrew history. When Joshua was planning his campaign for the conquest of Canaan *(Joshua 5:2)* the Biblical record is that the Lord

commanded Joshua to make himself sharp stones and circumcise the children of Israel before they invaded the promised land. This was because during their previous 40 years of wandering in the wilderness the ceremony had been neglected. The warriors who had started out from Egypt were all "consumed," and obviously this had to be corrected since they were not considered to be proper warriors in their uncircumcised state. Quite an undertaking for Joshua, but he did it, and they rested there at Gilgal "until they were whole."

Then there was the story of Dinah, the daughter of Jacob, who had a romantic affair, somewhat less than prudent, with Schechem, son of Hemor, prince of the Hittites. The then equivalent of a shotgun wedding was not possible, since Dinah's brothers would not consent to the marriage unless Schechem and all of the tribe of the Hittites were circumcised. Schechem, a devoted lover, if there ever was one, consented cheerfully and he and all the Hittites were circumcised. Unfortunately all did not end well, for two of Dinah's brothers, Simon and Levi were not so easily appeased, and on the third day after this wholesale surgery, when the Hittites were in no fit condition to resist, set upon them and obliterated the tribe, prospective bridegroom included.

Later this outward and visible sign was enforced upon their enemies by the Hebrews in gruesome ways. When King Saul told young David to slay for him a hundred Philistines, David being an aspirant for the hand of Saul's daughter Michal, that doughty young warrior complied in good measure and brought back and threw down at the feet of the king not one but two hundred Philistine foreskins as evidence of faithful performance of his sanguinary mission.

ANTIOCHUS AND THE MACCABEES

Circumcision, as a distinctive tribal mark of the Hebrew tribes, at times had its disadvantages. Antiochus IV (Epiphanes) King of Syria 176-164 B. C., the tyrant who attempted to force Hellenic culture on the Maccabees, finally made life so difficult for them that some of them resorted to the stratagem of a corrective operation to conceal the fact of previous ritual circumcision. The tyrant had decreed death as a penalty for circumcision, and oppressed them by high taxes and extortion. Also, the fact that Greek custom required the youths to appear naked in the wrestling games and in the public baths was a cause for ridicule and scorn. Those who thus sought to escape persecution, social handicaps or financial penalties were called "epispadians."

Thus it is seen that this custom had a deep religious meaning for the Jews and for the Mohammedans as well and seems to have had some social and religious significance to the ancient Egyptians in the earliest times of which a record remains, and its origin much farther back in equatorial Africa seems probable.

A TRIBAL SYMBOL

Whatever its origin or purpose, anthropologists have found it a tribal custom in use in many parts of the world. It has been described as a fertility rite, an initiatory ceremony at the time of receiving youths into full membership in the tribe, a religious ritual, in some areas as a symbolic substitute for human sacrifice or as a hygienic measure. It was practiced by the Aztecs, the Incas, Indian tribes of South America, among primitive tribes in Asia and Africa. That it was found in Mexico and in Central and South America tempts one to think of the legend of the lost tribes of Israel. The migration of tribes from Burma, to Malaya, Sumatra, Java, New Guinea, and Australia has been traced through study of this custom and its variations. Among these primitive peoples where the custom prevailed, no uniformity in method and no elaborate religious rites have been described in the reports of travelers and explorers in the accounts of their travels and observations.

A SANITARY MEASURE

In general it may be said to be observed chiefly in the tropics, from the equator to the thirtieth parallel, not only in Africa but in South America and the Pacific islands as well. The fact that it has been found chiefly in hot countries doubtless is related to sanitary reasons, possibly also to a racial tendency to redundant prepuce said to be characteristic of certain African tribes, Egyptians and Arabs, with the resulting difficulty in cleansing leading to balanitis, posthitis and herpes—conditions not so likely to occur in colder regions.

Occasional mention of a fatal infection, probably anthrax, in the literature on this subject prompts the surmise that this disease which obviously might easily complicate any of those conditions, may have been one of the reasons for the general practice of circumcision among the Semitic tribes, Hebrews, Arabs, and other shepherd peoples. Some ancient authors referred to it as "the wrath of God visited upon the uncircumcised."

Various reports of travelers indicate how widely this practice has spread. In the South Sea islands a method of performing a dorsal slit is described. This was done when the boy reached the age of puberty, a rod wrapped in a rag being inserted into the preputial orifice and a cut made dorsally with the rod as a guide. As after treatment the sap of a plant (papaya) was rubbed into the wound. The operator stayed in the home of the patient during the convalescence, being feasted generously, mean-

while, and on leaving received a roast pig as a fee.

The Tartars, Moslems who provide an exception to the general rule that circumcision was confined to hot regions, practiced it as a religious rite, and an occasion for prolonged feasting. Groups of boys from six to fourten years, as many as could be got together at the same time were initiated into the tribe under Musselman law, by being circumcised. A long and gruesome description of the bloody technical details is given by Johann George Gmelin in his account, *Journey in Siberia* 1733-43. He noted the prolonged and painful convalescence and the not rare occurrence of a "nervous twitching" as a complication with fatal results, tetanus, no doubt.

Since circumcision has been from the earliest times a part of the ritual of the Hebrews, its more recent history can be followed in the story of the Jewish people.

After the second destruction of the temple at Jerusalem by Titus, A. D. 70, the Jews were scattered to all parts of the world, taking with them their religious rites and social customs. Circumcision, one of their distinctive customs, was frequently the subject of the severest restrictive penalties as a part of the persecution which they suffered at the hands of various rulers.

PUNITIVE RESTRICTIONS

The Emperor Trajan in Cyprus was particularly severe. Adrian, A. D. 130, inflicted the death penalty. Antoninus, A. D. 140, for a time permitted it but in A. D. 160 it was again forbidden. When Christianity became the official state religion under Constantine, A. D. 315, Jews were permitted to circumcise their own children, but not non Jews.

A liberal view was taken by Charlemagne, then for about three centuries the whim of various ruling princes governed the matter. From about A. D. 700 for about seven centuries, while Spain was the cultural center of Jewry and was under the rule of the Moors, persecution was cruel. In 1492 both Moors and Jews were expelled from Spain and Portugal as well. From that time until early in the 19th Century circumcision was permitted or forbidden in the various countries where the Jews had taken refuge, as happened to be the will of the reigning monarchs.

About 1818, as a result of the deaths of seven children due to infection attributed to the negligence of a ritual circumciser, the Prussian Government passed some sanitary regulations to be observed by these operators and later in 1830 an agreement was reached with the Israelitish Consistory on licensing and controlling these persons. Interest of government authority was aroused and about 1840 Germany and France forbade the practice of suction by the mouth of the operator and the tearing of the inner membrane by the nails.

Long before any governmental sanitary regulations were adopted, the ritual recognized that there was an hereditary tendency to uncontrollable bleeding. It was provided that if a woman had lost two sons from bleeding after circumcision, no later male infant should be subjected to the same procedure. There are passages in the Talmud indicating that the hereditary nature of this disease was known at a very early date, though it does not appear in medical literature until about 1793. It was also recognized in the ritual that an infant whose skin was unduly yellow or red (cyanotic?) was a bad risk and that in case of a child who was, on the prescribed day, actuely ill the operation was to be deferred until seven days after recovery from the illness.

Many theories have been proposed for the widespread observance of this custom.

1. Among the Hebrews and Moslems as a religious rite, originating in the command to Abraham.

2. Mythological; a substitute for the pagan custom of human sacrifice, to appease the gods.

3. Symbolic adoption of the child into family, of adults into the tribe.

4. As a mark of military caste, as among the Egyptians and later the Hebrews.

5. As a protection against evil spirits, as in the Biblical story of the circumcision by Ziporah of Moses' son.

6. As a fertility rite among primitive tribes.

7. As a hygienic and prophylactic measure in tropical countries.

Where tribal leaders imposed this custom it appears likely that while one or the other of these reasons and possibly others were ascribed in establishing a ritual observance, the underlying common purpose of the laws was the recognition by the leaders of its hygienic value to the individual and to the race.

This oldest of surgical procedures is thus seen to have been developed independently in many parts of the world and to have been given symbolic meaning in many different ways by many different races of man.

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A. M. A. Session in Review . . .

House of Delegates Clamps Down on Fee Splitting, Discusses Relations With Osteopaths, Medical Care Plans, Veterans' Care and Other Matters

FEE SPLITTING, osteopathy, closed panel medical care plans, veterans' medical care and the training of foreign medical school graduates were among the major subjects of discussion and action during the sessions of the House of Delegates at the American Medical Association's 103rd Annual Meeting June 21-25 in San Francisco.

Named as president-elect for the coming year was Dr. Elmer Hess, of Erie, Pa., who, until his election, was serving as a member of the House of Delegates and as Chairman of the Council on Medical Service. Dr. Hess will become president of the American Medical Association at the June, 1955, meeting in Atlantic City, succeeding Dr. Walter B. Martin of Norfolk, Va. Dr. Martin took office at the Tuesday evening inaugural session in San Francisco's Palace Hotel, succeeding Ohio's Dr. Edward J. McCormmick, of Toledo.

The House of Delegates voted the 1954 Distinguished Service Award of the American Medical Association to Dr. William Wayne Babcock of Philadelphia for his outstanding contributions to medicine and humanity. Dr. Babcock, who was professor of surgery and clinical surgery at Temple University School of Medicine from 1903 to 1944, received the award from Dr. Martin at the Tuesday evening inaugural ceremony.

The registration total for the San Francisco meeting was approximately 35,000, including 12,063 physicians.

OHIO DELEGATES

Several of Ohio's delegates served on important reference committees of the A. M. A. House of Delegates.

Dr. Herbert B. Wright, Cleveland, was chairman of the Committee on Rules and Order of Business.

Dr. A. A. Brindley, Toledo, served on the Committee on Amendments to the Constitution and By-Laws.

Dr. C. C. Sherburne, Columbus, served on the Committee on Medical Military Affairs.

Other Ohio delegates were Dr. Carl A. Lincke, Carrollton; Dr. William M. Skipp, Youngstown; Dr. George A. Woodhouse, Pleasant Hill; and Dr. L. Howard Schriver, Cincinnati. Dr. Paul A. Davis, Akron, represented the Section on General Practice.

Accompanying the Ohio delegation were Mr. Charles S. Nelson, Executive Secretary, and Mr. George H. Saville, Director of Public Relations of the Ohio State Medical Association.

FEE SPLITTING

The House adopted a supplementary report of the Reference Committee on Miscellaneous Business which recommended acceptance of a Judicial Council report on the subject of billing and made the additional recommendation "that the House of Delegates resolve that it firmly opposes fee splitting, rebating or payment of commissions in any guise whatsoever, and that it further opposes any mechanism that encourages this practice."

Refer to July issue of *The Journal* for list of Ohioans who took part in program and other information about the San Francisco meeting.

The Judicial Council report included the following statements:

"The Judicial Council is of the opinion that the only new facet concerning this subject that has come up recently is the case of joint billing to some of the nonprofit insurance companies. In many cases these insurance companies insist on a joint or combined bill, but the bill is being paid in most instances by two checks. This is not considered unethical and all insurance plans which do not pay the individual physician in this manner should be urged to do so.

"The Judicial Council is still of the opinion that when two or more physicians actually and in person render service to one patient they should render separate bills.

"There are cases, however, where the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur it is considered to be ethical if the physician from whom the bill is requested renders an itemized bill setting forth the services rendered by each physician and the fees charged. The amount of the fee charged should be paid directly to the individual physicians who rendered the services in question.

"Under no circumstances shall it be considered ethical for the physician to submit joint bills unless the patient specifically requests it and

unless the services were actually rendered by the physicians as set out in the bill."

OSTEOPATHY AND MEDICINE

Four resolutions dealing with the osteopathic problem were considered. The House accepted a recommendation by the Reference Committee on Medical Education and Hospitals and adopted a Supplementary Report of the Board of Trustees on a Report of the Committee for the Study of Relations Between Osteopathy and Medicine:

"The justification or lack of justification of the 'cultist' appellation of modern osteopathic education could be settled with finality and to the satisfaction of most fair-minded individuals by direct on-campus observation and study of osteopathic schools. The Committee, therefore, proposed to the Conference Committee of the American Osteopathic Association that it obtain permission for the Committee for the Study of Relations between Osteopathy and Medicine to visit schools of osteopathy for this purpose.

"The Conference Committee favorably recommended this proposal to the board of trustees of the American Osteopathic Association which considered it at a special meeting on February 6-7, 1954. It has referred the question to its house of delegates which will act upon the proposal in July, 1954. If the action of the house of delegates of the American Osteopathic Association be favorable, the on-campus observations can be carried out in the fall of this year.

"The Committee therefore recommends:

1. That no action be taken on the report at this time and that final action be deferred until December, 1954.

"2. That the Committee be continued until December, 1954, in order to be available to evaluate education in schools of osteopathy should the house of delegates of the American Osteopathic Association act favorably upon the recommendation of its Conference Committee."

CLOSED PANEL PLANS

The much-publicized New York resolution, calling for several changes in the Principles of Medical Ethics relative to participation in closed panel medical care plans, was considered by the Reference Committee on Miscellaneous Business. That committee made the following recommendation, which was adopted by the House:

"In the discussion before your reference committee on this resolution, it became apparent to the committee that clarification and interpretation of the Principles of Medical Ethics in relation to prepaid medical care plans are desirable. As set forth in the bylaws, the Judicial Council has jurisdiction on all questions of medical ethics.

"Therefore, your reference committee recommends that the House of Delegates request the Judicial Council to . . . investigate the relations of physicians to prepaid medical care plans and render such interpretations of the Principles of Medical Ethics as the Council deems necessary, and report to the House of Delegates not later than the next annual meeting of the Association.

"The committee further recommends that the New York resolution be referred to the Judicial Council for consideration in connection with this investigation."

The New York resolution, among other suggested changes, would add the following new paragraph to Chapter 1, Sec. 4, "Advertising," of the Principles of Medical Ethics:

"It should be understood that any medical care plan, company, or organization which advertises for subscribers and directs such subscribers to a restricted panel of physicians for medical care is advertising for the benefit of the physicians involved."

VETERANS' MEDICAL CARE

Accepting a report by the Reference Committee on Legislation and Public Relations, the House adopted two strong resolutions condemning the present practice of establishing service-connection for veterans' disabilities by legislative fiat. The report of the Reference Committee was based largely on a resolution presented by Dr. Sherburne of Ohio. In recommending passage of both resolutions, the committee said:

"The study of the chronological expansion by law and regulation, together with evidence presented of pending legislation now before a Congressional Committee, emphasize all too clearly the imperative need of decisive action on the part of the American Medical Association.

"It is the opinion of the Committee that the time is at hand when the American Medical Association and its component societies should go all out in preventing this unscientific method of determination of service-connected disabilities, and that we respectfully request that copies of these resolutions be transmitted to the Congress of the United States and other appropriate federal agencies."

In connection with veterans' medical care, the House also adopted recommendations by the Reference Committee on Insurance and Medical Service which reaffirmed the policy on non-service-connected disabilities, established at the 1953 annual meeting, and which commended the informational program carried out since then by the Committee on Federal Medical Services of the Council on Medical Service.

FOREIGN MEDICAL GRADUATES

Three resolutions and a Board of Trustees supplementary report were submitted to the House regarding the evaluation of foreign medical school graduates, a subject which attracted major interest earlier this year at the annual Congress on Medical Education and Licensure in Chicago. The Reference Committee on Medical Education and Hospitals spent much of its time listening to the ideas and proposals of various state medical

societies, state licensing boards, members of the Council on Medical Education and Hospitals and others. The reference committee recommended that "the intent and aims of this Supplementary Report and the three resolutions can best be met by referring the entire problem to the Council on Medical Education and Hospitals for further study. It is recommended that the Council report at the Interim Session in 1954 regarding the progress relative to this study." The House adopted the reference committee's recommendations.

SEAL OF ACCEPTANCE

The Council on Medical Service presented a supplementary report outlining the difficulties encountered in conducting the Seal of Acceptance program, and recommending discontinuance of the Seal of Acceptance for voluntary health insurance plans. The report said that the standards and principles of the program will be maintained as guides and recommendations for all groups operating or establishing plans. The House, on recommendation of the Reference Committee on Insurance and Medical Service, adopted the Council report, thus terminating the Seal of Acceptance program for voluntary health insurance plans.

REGISTRATION OF HOSPITALS

The House also approved a Board of Trustees report calling for discontinuation of the registration of hospitals by the Council on Medical Education and Hospitals and suggesting that the Joint Commission on the Accreditation of Hospitals be requested to undertake the registration of hospitals in addition to its present accreditation activities.

ACCREDITATION OF HOSPITALS

Dr. Skipp presented a resolution dealing with accreditation of hospitals on behalf of the House of Delegates of the Ohio State Medical Association as requested at the 1954 Annual Meeting. The resolution was referred by the A. M. A. House of Delegates to the Board of Trustees for consideration.

The resolution requested that the Joint Commission on Accreditation of Hospitals take the following actions:

"1. That the Commission repeal the existing requirements concerning attendance at hospital staff meetings;

"2. That the Commission omit entirely from its regulations any requirement for staff meeting attendance as a part of the hospital accreditation procedure;

"3. That the Commission adopt the policy that the matter of attendance at staff meetings be left to the autonomy of the medical staff of the individual hospital."

MISCELLANEOUS

Among a wide variety of other actions, the House also:

Voted to continue the holding of the annual Clinical Meetings;

Approved the establishment of a program of medical military scholarships with appropriate safeguards limiting the number of students involved;

Approved the extension, on a voluntary basis, of the Medical Education for National Defense program which currently is in operation in five medical schools as a pilot study; and

Authorized the Council on Scientific Assembly to conduct a thorough study of the use of tape recordings of the material presented at meetings of the Council, and asked for a report at the December meeting.

Dr. Wright introduced a resolution dealing with examination of civilian airplane pilots which was adopted by the House of Delegates. It directs the A. M. A. to strongly recommend to the Secretary of Commerce and the Administrator of the Civil Aeronautics Administration the continuation of "the present effective and medically sound program of medical certification of civilian pilots by qualified civilian physicians."

OPENING SESSION

Highlights of the opening House session on Monday were selection of Dr. Babcock as recipient of the Distinguished Service Award and the addresses by Dr. McCormick, then president of the Association, and Dr. Martin, then president-elect.

Dr. McCormick called upon the medical profession to take the guess work out of medical costs by adopting average fee schedules on an area or regional basis. The Reference Committee on Reports of Officers later suggested that the Board of Trustees make a study of such programs where they already are in operation, and the House approved.

Dr. Martin, in his opening session address, declared that the most urgent problem before the medical profession is that of financing hospital services to make them more generally accessible. In his presidential inaugural address, Dr. Martin said that physicians are duty-bound to keep themselves informed on public matters affecting the medical welfare of the people, and he also urged doctors to "reach back farther than the disease" in treating their patients.

SPECIAL CITATIONS

Two special citations were presented by the Association during the San Francisco meeting. During the presidential inauguration ceremony Dr. McCormick presented an award to a fellow Toledoan, Dr. Nicholas P. Dallis, for his outstanding health educational service as the writing member of the team that produces the illustrated feature, "Rex Morgan, M. D." At the closing House session on Thursday, Dr. Martin presented a special citation to Smith, Kline & French Laboratories of Philadelphia for "pioneer-

ing use of television in bettering the health of the nation." The plaque was accepted for the company by Mr. Francis Boyer, president.

The closing session also brought the announcement that the California Medical Association had presented a check for $100,000 to the American Education Foundation.

ELECTION OF OFFICERS

The election at the closing session brought the following results, in addition to the selection of Dr. Hess as president-elect:

Dr. Clark Bailey of Harlan, Ky., was named vice-president.

Dr. David B. Allman of Atlantic City and Dr. F. J. L. Blasingame of Wharton, Texas, were reelected to their positions on the Board of Trustees.

Also reelected were Dr. George F. Lull of Chicago, secretary; Dr. J. J. Moore of Chicago, treasurer; Dr. James R. Reuling of Bayside, N. Y., speaker of the House of Delegates, and Dr. Vincent Askey of Los Angeles, vice-speaker.

Dr. J. Morrison Hutcheson of Richmond, Va., was named by Dr. Martin as a member of the Judicial Council to succeed Dr. Edward R. Cuniffe of New York, who served as Council chairman for many years. Dr. Homer Pearson of Miami, Fla., was elected new chairman.

Dr. W. Andrew Bunten of Cheyenne, Wyo., was elected a new member of the Council on Medical Education and Hospitals, succeeding Dr. W. L. Pressly of Due West, S. C. Dr. Charles T. Stone, Sr., of Galveston, Texas, was reelected to the same Council. Both terms run to 1959.

Dr. Floyd S. Winslow of Rochester, N. Y., was reelected to the Council on Constitution and By-Laws for a term ending in 1959.

Dr. Joseph D. McCarthy of Omaha, Neb., was reelected to the Council on Medical Service for another term running to 1959. To fill the vacancy created on the same Council by Dr. Hess' resignation following his election as president-elect, Dr. Robert L. Novy of Detroit, Mich., was selected.

The House of Delegates also chose New York City as the place for the 1957 annual meeting, San Francisco for 1958 and Atlantic City for 1959. Previously selected were Atlantic City for 1955 and Chicago for 1956. The dates of next year's meeting in Atlantic City are June 6-10.

Of those who attended the San Francisco meeting, 104 Ohio doctors and their wives enjoyed a Special Train Tour arranged by Mr. Nelson. The special train left Chicago on June 12 with a stopover at Denver, scenic trip through the Royal Gorge and tours at Salt Lake City, Los Angeles and other points of interest. The tour continued north after the meeting with sightseeing in Portland, the Columbia River Gorge, Glacier National Park and many other interesting points along the northern route, arriving in Chicago on July 3.

Aviation Medicine for Civilians To Be Subject at Ohio State

A one week refresher course in aviation medicine for civilians is to be given at the Ohio State University Medical Center during the week of September 13. The course is sponsored jointly by the O. S. U. College of Medicine and by the Civil Aeronautics Administration and is approved by both the Aero Medical Association and the Airline Medical Examiners Association.

The course will be approximately 80 per cent clinical. Topics to be covered include two half-day sessions on cardiovascular disease, in which recent advances will be covered. It will also include discussions of balistocardiography and vector cardiography. Lectures in this field will be given by Dr. John E. Smith of Washington, D. C. Dr. Willis Hurst, of Emory University Hospital, Atlanta, Georgia, has been invited to give the lecture on vector cardiography. The more general aspects of this field are to be covered by Dr. Joseph M. Ryan, Department of Medicine, O. S. U.

There will be half day sessions on each of the following topics: Ophthalmology and visual problems—lectures to be given by Dr. Hedwig Kuhn of Kansas City, Mo., and Dr. Glen Fry, of the O. S. U. School of Optometry; Otolaryngology—Dr. Delazon Bostwich has been invited to give the lectures in this field; Endocrine and metabolic disorders—Dr. G. J. Hamwi, Department of Medicine, O. S. U., will be in charge; Psychiatry including the problems of the aging pilot—Dr. Douglas Bond, professor of psychiatry at Western Reserve University, has been asked to give the lectures on this topic. Respiratory and pulmonary function tests—this will be in charge of Dr. Joseph Tomashafski, chief of research of the Ohio Tuberculosis Hospital.

Non-clinical topics covered will include a lecture by Dr. W. R. Stovall, Chief of the Medical Section of the Civil Aeronautics Administration, on the future of Aviation Medicine; Dr. Barry King, research executive of the Civil Aeronautics Administration, on medical aspects of accelerative forces; Dr. Paul Fitts of the Psychology Department of the Ohio State University on the psychological evaluation of airmen; Dr. Fred Hitchcock, professor of physiology, O. S. U., on physiological aspects of cabin pressurization; and Dr. C. R. Spealman, of the Medical Division of the Civil Aeronautics Administration, on Aviation Toxicology.

There will also be a trip to Wright Patterson Air Force Base for the purpose of inspecting the Aero Medical Laboratory and there will be a round table discussion on present physical standards for airmen. Further information can be obtained by addressing Dr. Richard L. Meiling, Associate Dean of the College of Medicine, Ohio State University.

State Medical Board Examinations . . .

403 Graduates of Medical Schools Seek Licenses to Practice in Ohio; List of Questions Are Given; Many in Limited Field Also Examined

THE State Medical Board of Ohio gave examinations to 403 graduates of medical schools who were candidates for licenses to practice medicine and surgery in the State, on June 15-17, Dr. H. M. Platter, Secretary of the Board, reported.

In addition, it gave examinations to 74 persons seeking licenses to practice osteopathic medicine and surgery. In the limited practice field the following persons were examined: 50 in chiropody; 18 in mechanotherapy; 59 in chiropractic; 37 in massage; and 9 in cosmetic therapy—a total of 247 in addition to the M. D.'s.

Results of the examinations will be announced following a meeting of the Board on August 31.

Following are the questions given in the examinations for doctors of medicine:

ANATOMY

1. Describe the blood supply of the stomach.
2. Outline the changes that occur in the fetal circulation at birth.
3. Describe the anatomy of the tonsils.
4. What is the histological structure of the kidneys?
5. Diagram the sensory nerve supply of the hand.
6. Name the muscles of mastication and give their nerve supply.
7. By what means and into what structures is malignancy of the breast metastasized?
8. Describe the muscles of the abdominal wall.
9. Outline the gross anatomy of the thyroid.
10. What anatomical structures may be seen on anoscopic and proctoscopic examination?

PHYSIOLOGY

1. Explain the effect of high altitude upon the composition of alveolar aid and played of urine.
2. Describe the role played by the sympathetic division of the autonomic nervous system in the regulation of body temperature.
3. State and explain the effects upon the respiratory movements of (a) complete transection of the spinal cord at the lowest cervical segment; (b) section of the vagi at a mid-cervical level.
4. Discuss the physiology of the adrenal cortex.
5. Discuss the relation of the cerebral cortex to the tone of skeletal muscle.
6. What is known of the cause or causes of diuresis that follows ingestion of a moderate amount of water?
7. Compare and contrast: (a) the functions of saliva and pancreatic juice; (b) the factors influencing the flow of these two secretions.
8. Discuss the factors which determine the flow of blood through the brain.
9. What factors determine the oxygen content of blood in the right auricle of the heart?
10. What factors determine the level of arterial blood pressure in a normal individual at rest?

BACTERIOLOGY

1. List three systemic mycotic infections and name the etiologic agent of each.
2. Name the serological tests of value in the diagnosis of: (a) Influenza; (b) Histoplasmosis; (c) Psittacosis; (d) Infectious mononucleosis; (e) Atypical pneumonia of viral etiology.
3. List four examples in which phenomena of hypersensitivity must be taken into account either in diagnosis or treatment.
4. Give the laboratory procedures to be undertaken before a blood transfusion. Describe the reaction present indicating an unsatisfactory donor.
5. What is meant by the RH factor in the blood and discuss its significance in child bearing.

DIAGNOSIS

1. Describe the changes in the ocular fundus of patients with benign arteriosclerosis.
2. Give the differential diagnosis between cardiospasm and carcinoma of the lower end of the esophagus.
3. Give the differential diagnosis between: (a) carcinoma of the head of the pancreas; (b) Laennec's cirrhosis of the liver.
4. Give the diagnosis of subacute bacterial endocarditis (endocarditis lenta).
5. Discuss the diagnosis of disease of Meckel's diverticulum.
6. Discuss the diagnosis of unilateral bronchiectasis.
7. On what grounds would you make a diagnosis of aplastic anemia?
8. Give the symptoms and the results of laboratory and x-ray studies that may be expected in hyperparathyroidism.
9. Discuss the symptoms, the physical signs, and laboratory observations in a patient with infectious mononucleosis.
10. Discuss the differential diagnosis of acute pericarditis in a man twenty years of age.

CHEMISTRY

1. What are the outstanding biochemical advantages and limitations of each of the following food groups in nutrition: (a) milk; (b) white flour; (c) citrus fruits; (d) green leafy vegetables; (e) muscle meats.
2. Discuss briefly the chemical characteristics of the chief organic constituent of muscle tissue.
3. Discuss the deposit of glycogen in the liver, as to sources.
4. It is said that the hydrogen ion concentration of the blood is not materially affected by the addition of relatively large quantities of acid or basic substances. Describe the buffer systems as they relate to this constancy of reaction.
5. (a) The normal CO_2 combining power of the blood is ..... ? (b) In severe diabetic coma it could be in the following range ..... ? (c) Intracellular fluid comprises what per cent of body weight ..... ? (d) Extracellular fluid comprises what per cent of body weight ..... ?

MATERIA MEDICA AND THERAPEUTICS

1. (a) Define a hormone.
   (b) Give one possible way in which one endocrine gland may influence another endocrine gland.
2. Enumerate 6 methods of drug administration.
3. Name one drug that stimulates the following and give dosage: (a) Cerebrum; (b) Medulla; (c) Spinal Cord.
4. Give the effect of small concentrations and high concentrations of potassium salts upon cardiac action.
5. (a) Name 2 symptoms of poisoning. (b) The mechanism of the action on tissue producing symptoms.
6. Give the treatment of agranulocytosis.
7. Outline the treatment of subacute bacterial endocarditis.
8. What precautions should be taken with patients receiving sulfonamide therapy.
9. Enumerate four uses for serums and vaccines.
10. Describe the action of morphine when given in: (a) therapeutic dose; (b) toxic dose.

PRACTICE

1. Give the signs and symptoms of pulmonary tuberculosis.
2. Enumerate the causes of convulsions in different age groups.
3. Give the complications produced by hemorrhage.
4. Give the symptoms and complications of meningococcal infections.
5. Define scleroderma—give the symptoms and signs.
6. Outline the treatment of gout.
7. What is treatment of acidosis in a diabetic patient?
8. In what circumstances should a patient with duodenal ulcer be treated by medical means?
9. Name two anti-coagulant drugs. Discuss the indications

for their use, the methods of administration, and the precautions required for safety.
10. Give the treatment for catarrhal jaundice.

PATHOLOGY

1. In the sequence of their occurrence, list the histological changes in a coronary artery in the course of occlusion due to arteriosclerosis.
2. In outline form, give the microscopical picture of the lung in death from primary atypical pneumonia.
3. List the possible causes of chronic constrictive pericarditis.
4. Of what disease is acute focal glomerulonephritis most likely to be a complication?
5. Name two diseases that may be complicated by the occurrence of Zenker's hyaline necrosis (degeneration) of skeletal muscle.
6. Outline the available biological measures for the prophylaxis of the following diseases and indicate the approximate duration of the resulting effective immunity in each instance: (a) smallpox; (b) measles; (c) yellow fever; (d) diphtheria; (e) cholera.
7. In outline form give the gross and microscopical findings of a medulloblastoma.
8. What lesions of the endocrine organs may be present in pituitary basophilism (Cushing's disease)?
9. List the primary and secondary anatomic changes in carcinoma of the head of the pancreas.
10. List the causes of hypoglycemia.

SURGERY

1. List, without discussion, the important points in differential diagnosis between tuberculosis of the kidney and stone in the renal pelvis.
2. Discuss pyloric stenosis in infancy.
3. Enumerate the significant points that lead to a diagnosis of intussusception.
4. Give the indications for operation in cholelithiasis.
5. What is penicillin? Give the indications and contraindications for its use in surgery.
6. Give the etiology, the physiological considerations, and the pathology of arteriovenous fistula.
7. What are the causes of alkalosis in surgical conditions? Discuss briefly its recognition, its physiological significance and its treatment.
8. What principles underlie the treatment of gunshot wounds of the abdomen? (Omit operative technic).
9. Discuss the frequency, the pathogenesis and the prophylaxis of pulmonary embolism.
10. Give the indications for skin grafting and types of graft. Describe one method of skin grafting.

OBSTETRICS AND GYNECOLOGY

1. Give causes, symptoms and treatment for prolapse of the uterus.
2. How is a face presentation diagnosed and delivered?
3. Describe the fetal circulation.
4. Discuss the etiology and treatment of post partum hemorrhage.
5. Give etiology, symptoms and treatment of femoral thrombo phlebitis.
6. Discuss diagnosis and management of placenta praevia (a) Centralis; (b) Marginalis.
7. An eight month pregnant patient shows albumin in the urine and a beginning hypertension—discuss management.
8. A woman patient, age 32, complains of profuse and prolonged menstrual periods. How would you manage her?

9 & 10. In the following statements, differentiate between abruptio placenta and placenta previa:
(a) Abdomen distended, tense and painful to touch.
(b) Uterus tense, boardlike and cannot feel foetus.
(c) Foetal heart tones absent.
(d) Fetal heart tones almost always present.
(e) Placenta palpable in isthmus uteri.
(f) Bag of water loose; usually head not engaged.
(g) Bag of water tense—can feel head easily.
(h) Abdomen as usual at time of pregnancy.
(i) Vaginally no placenta in reach of the fingers.
(j) Uterus soft unless there is an uterine contraction.

SPECIALTIES

1. Describe the anatomy of the skin (epidermis and dermis) and name all the important structures therein.
2. Describe the diseases of the ear and possible complications arising therefrom.
3. Differentiate hypertrophy of the prostate gland from prostatitis. What is the treatment for each?
4. How would you treat a patient who came into your office with: (a) red blood cells in urine; (b) white blood cells in the urine.
5. True or False?
   (a) Papilledema is characteristic of increased intraocular tension.
   (b) Heterophoria is a muscle imbalance that is not manifest.
   (c) Hyperopia is a short (D-P diameter) eyeball.
   (d) Sympathetic ophthalmia may follow a trauma to the ciliary body.
   (e) A cupping of the optic disc is characteristic of increased intracranial pressure.

PREVENTIVE MEDICINE AND HYGIENE

1. What is the cause and means of prevention of silicosis?
2. What measures should be established to prevent and what should be done to eradicate tinea tonsurans?
3. Give the period of incubation, means of communication and necessary period of isolation in: (a) rubeola; (b) varicella; (c) variola.
4. What is occupational disease? Give three examples, telling how usually contracted and means of prevention.
5. What measures should be taken in a rural county (population under 50,000) to guard against typhoid fever?

Physicians Licensed To Practice By the State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians, one by examination and the others by endorsement of their licenses to practice in other states (intended residence and medical school of graduation also is given):

April 13: By examination, Jan Falenski, Columbus, University of Warsaw.

April 13: Louise J. Keating, Lakewood, University of Michigan; Frank T. Hamilton, Barberton, Loyola Univ.; Leonard Seidenberg, Wooster, Jefferson Medical College; Albert C. Smith, Jr., Cincinnati, Medical College of South Carolina; Charles M. Yergan, Cleveland, Columbia University.

June 17: Robert U. Anderson, Cincinnati, Indiana Univ.; Glenn E. Austin, Cincinnati, Stanford Univ.;

Charles S. Ballinger, Cleveland, Harvard Med. School; John C. Bates, Fremont, State Univ. of Iowa; Maria Bauer, Univ. of Bonn (Germany); Otto F. Bauer, Univ. of Bonn (Germany); Donald J. Bourg, Cincinnati, Univ. of Michigan; Clifford C. Bowen, Toledo, Univ. of Michigan; John R. Bowman, Eaton, Vanderbilt Univ.; Herbert Braunstein, Cincinnati, Hahnemann Med. Col.;

Joseph J. Campolito, Boardman, Indiana Univ.; Myra E. Chatters, Columbus, Howard Univ.; Kathryn M. Defler, Cincinnati, Washington Univ.; John D. Des Prez, Jr., Cleveland, Harvard Med. School; Ellery T. Drake, Cincinnati, Harvard Med. School; Mary E. Dufner, Canton, Woman's Med. Col.; Pantalejmon Dziad, Toledo, Univ. of Erlangen (Germany);

Charles E. Eby, University Heights, Univ. of Pennsylvania; Richard R. Evans, Cleveland, Albany Med. Col.; Stephen M. Field, Cleveland, Univ. of Southern California; Roy J. Fischer, Univ. of Amsterdam (The Netherlands); Z. Charles Fixler, Cincinnati, Univ. of Lausanne (Switzerland); Donald E. Fleming, Marietta, Med. Col. of Virginia; Clynn R. Ford, Cincinnati, Northwestern Univ.; Fred M. Friedman, Youngstown, Univ. of Tennessee; Charles T. Fultz, Cincinnati, Univ. of Pennsylvania; Paul O. Funk, Cleveland, Univ. of Frankfurt/Main (Germany);

George J. Gabuzda, Cleveland, Harvard Med.

School; Ciprijans Garancs, Cleveland, Univ. of Heidelberg (Germany); Geza Gaspar, Youngstown, Univ. of Pecs; Ronald O. Germain, Cincinnati, Harvard Med. School; Virgil R. Graber, Hartville, State Univ. of Iowa;

William A. Hagen, Geo. Washington Univ.; Paul G. Haltenberger, Cleveland, Univ. of Budapest (Hungary); Leslie Hampton, Jr., Springfield, Indiana Univ.; Paul S. Hough, Cincinnati, Meharry Med. Col.; Brooks H. Hurd, Columbus, Boston Univ.; Francis H. Hutchinson, Cincinnati, College of Physicians and Surgeons, Baltimore.

John B. Jackson, Jr., Columbus, Meharry Med. Col.; John P. Jasko, Lakewood, St. Louis Univ.; Clifford A. Johnson, Jr., Chillicothe, Creighton Univ.; John T. Jones, Jr., Painesville, Johns Hopkins; Jefferson D. Kernodle, Cleveland, Univ. of Arkansas; James M. Knopp, Wooster, Univ. of Virginia; Leo S. Konieczny, Marietta, Loyola Univ.; John E. Kysar, Cincinnati, Univ. of Nebraska; John H. Lewis, Jr., Cleveland, Howard Univ.;

Randall J. McClelland, Dayton, St. Louis Univ.; Edward B. McGovern, Warren, Hahnemann Med. Col.; Richard G. Manthey, Cleveland, Geo. Washington Univ.; Eugene Marks, Seaman, Univ. of Prague (Czechoslovakia); Monte J. Meldman, Marquette Univ.; Edward W. Miller, Parma, Cornell Univ.; Alexander M. Minno, Univ. of Pittsburgh; Raymond H. Murray, Toledo, Harvard Med. School;

James J. Pampush, Lakewood, St. Louis Univ.; Jerome B. Peltier, Columbus, Louisiana State Univ.; John B. Rank, Toledo, Northwestern Univ.; Georgia Reynolds, Cleveland, Univ. of Maryland; Benigno J. Rodriguez, Akron, Univ. of Havana; Abraham M. Rudolph, Cleveland, Univ. of Witwatersrand (South Africa); William C. Sampson, Akron, Meharry Med. Col.;

Joseph A. Sanacore, Alliance, New York Univ.; William H. Saunders, Columbus, State Univ. of Iowa; Roland E. Schneckloth, Cleveland, Univ. of Nebraska; Marvin J. Schwarz, Dayton, Wayne Univ.; Byron E. Sheesley, Columbus, Univ. of Buffalo; William D. Shidal, Waverly, Univ. of Louisville;

Howard M. Simon, Jr., Cleveland, Univ. of Pittsburgh; Roy M. Smith, Jr., Dayton, Indiana Univ.; Truman S. Smith, Findlay, Northwestern Univ.; George D. Solomon, Jr., Akron, St. Louis Univ.; Robert B. Strother, Toledo, Univ. of Louisville; Theophil J. Sutton, Toledo, Univ. of Michigan;

William L. Telfer, Toledo, Univ. of Michigan; Elijah W. Titus, Jr., Canton, Geo. Washington Univ.; Charles J. Townsend, Springfield, Medical College of Virginia; Hans J. Van Baaren, Toledo, Univ. of Utrecht (Holland); Robert M. Vetto, Cincinnati, Jefferson Med. Col.; Johannes Virks, Cincinnati, Univ. of Goettingen (Germany); Alvin Volkman, Cleveland Heights, Univ. of Buffalo;

Gilbert P. Wagoner, Portsmouth, Univ. of Illinois; R. Alan Wickham, St. Louis Univ.; Morgan E. Wing, Waverly, Univ. of Louisville; Herbert L. Winograd, Cleveland, Washington Univ.; Woodrow W. Wren, Springfield, Med. Col. of Virginia.

Do You Know . . .

Dr. George T. Harding, Worthington, was reelected to serve another year as president of the Ohio Citizen's Council for Health and Welfare at the organization's 42nd annual meeting in Columbus.

* * *

Dr. William F. Ashe, chief of internal medicine at the Holzer Clinic, Gallipolis, has been named chairman of the Department of Preventive Medicine, College of Medicine, Ohio State University.

* * *

The University of Kentucky's Board of Trustees on June 1 formally approved establishment of a grade-A medical school in Lexington with the over-all plan envisioned to cost approximately $25,000,000. The University will request funds for the project from the Kentucky General Assembly.

* * *

David Dietz, science editor of *Scripps-Howard Newspapers* and a member of the *Cleveland Press* staff, is this year's winner of the national Lasker Medical Journalism Award for outstanding reporting on medical research and public health in the newspaper field. He was particularly cited for his series of articles on iron lung patients.

* * *

At the 50th anniversary meeting of the National Tuberculosis Association in Atlantic City, Dr. Colin R. Clark, Youngstown, was cited as one of the 10 surviving founders of the organization.

* * *

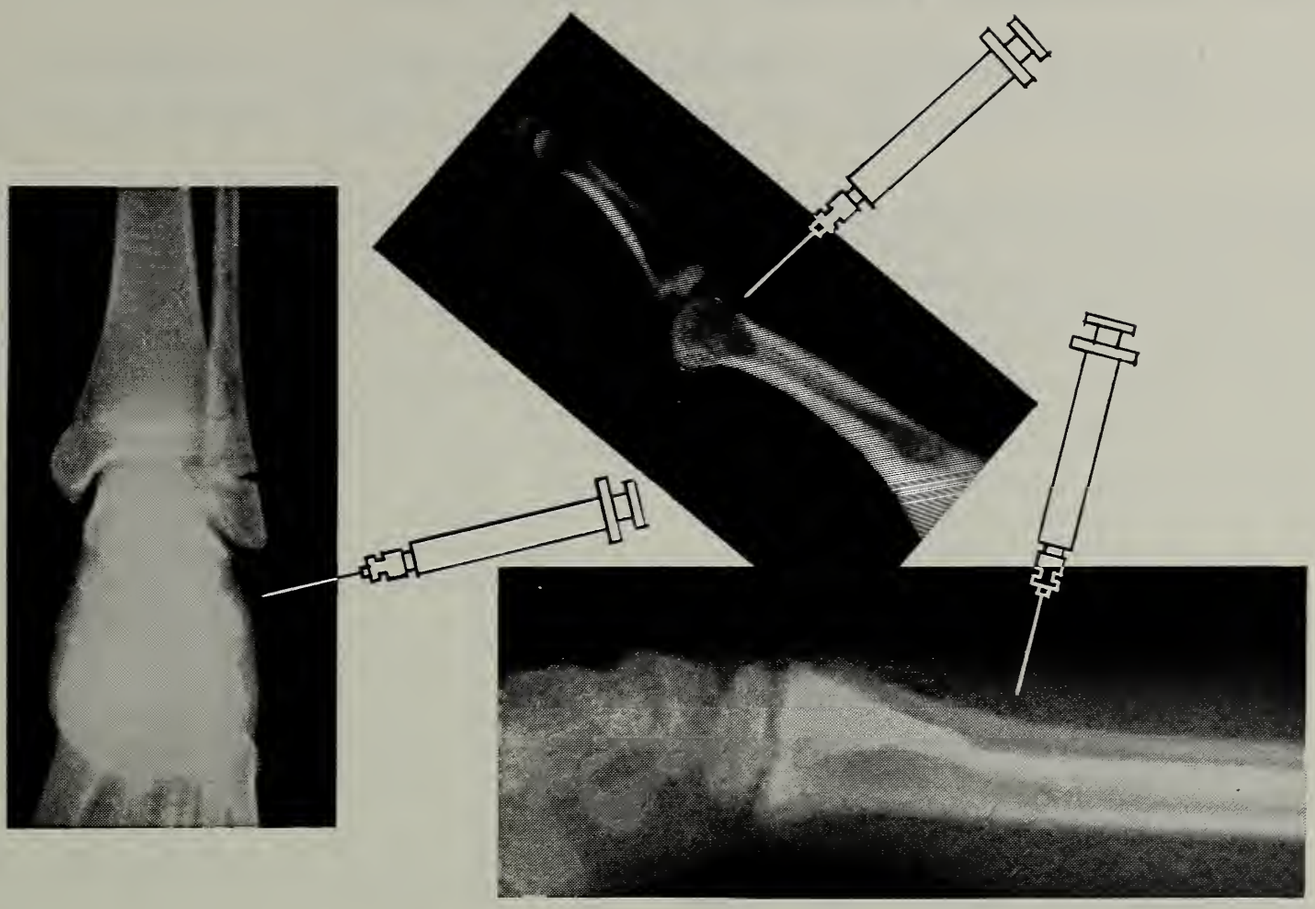
Dr. Joseph P. Evans, for many years associate professor of surgery in charge of neurological surgery at the University of Cincinnati College of Medicine, has resigned to accept an assignment as professor of neurosurgery at the University of Chicago.

* * *

The new law-medicine center at Western Reserve University received a $2,000 gift from Mrs. Frances Glessner Lee, of Littleton, N. H. Mrs. Lee in 1913 founded the department of legal medicine at Harvard University and in 1936 endowed the department. She belongs to the New England Policewomen's Association and the International Association of Chiefs of Police.

* * *

Dr. William L. Grover, for several years on the staff of the Columbus State Hospital, has been named superintendent of the Cleveland State Hospital.



Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

In traumatic surgery[1] where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means[1, 2] of accelerating dispersion of accumulated fluids.

Swenson[2] has described his highly successful results with Alidase in various types of closed wounds. He summarized them as follows:

To remove local fluid accumulations in contusions or bruises, "The usual dose, 500 viscosity units Alidase® mixed in a small amount of normal saline, is injected into the localized fluid. Mixing the hyaluronidase in 1 per cent procaine solution will also produce local vasodilatation, relief of local pain and more rapid absorption of the fluid mass. This method can also be applied to traumatized bursae or synovial spaces which do not respond to repeated aspirations."

The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anesthesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

Fluids administered with Alidase are rapidly absorbed from subcutaneous tissue. The simplicity of hypodermoclysis avoids the cumbersome arm board, permits convenient administration with little or no pain or swelling, is vein-sparing and saves nursing time in such conditions as burns, postoperative states, toxemias and parenteral alimentation.

Alidase (brand of hyaluronidase) is supplied in serum-type ampuls of 500 viscosity units. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1 MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, J. Bone & Joint Surg. *35-A*:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, Am. J. Surg. *87*:384 (March) 1954.

Deferments Being Rechecked . . .

National Advisory Committee Asks for Review of Status of All Doctors Vulnerable for Military Duty; Needs of Services Cited

RE-EVALUATION, looking toward possible reclassification, of all physicians who are vulnerable for active military duty but who are now on a deferred status, has been requested by the National Advisory Committee to Selective Service. Instructions to this effect have been received by the Ohio Advisory Committee and such information has been relayed to all county advisory committees by Dr. Drew L. Davies, chairman of the state committee.

Explanation for this new order is found in a bulletin from the National Advisory Committee dated July 7, which points out the urgent need for more available physicians to meet calls of the armed services for medical officers during the present fiscal year. The text of the bulletin from the National Advisory Committee is as follows:

Information Release No. 16
Subject: Reclassification of II-A Registrants

Under date of May 4, 1954, we issued Information Release No. 15 in which we pointed out that "every effort should be made to have those physicians in Priorities I and II and that portion of Priority III born after August 30, 1922, who will finish their internships and residencies by July first, apply at once for commissions so that there will not be a protracted period of waiting between the end of the hospital year and the call to active duty."

Furthermore, on November 10, 1953, we released Information Release No. 10 "Residents for the 1954-55 Hospital Year" in which it was pointed out that the hospitals should not appoint any physicians in the groups above for further training.

These are the groups that are most urgently needed to meet the future calls during this present fiscal year. It is essential, with few exceptions, that those who do not apply for commissions should at least have their II-A classifications terminated.

The Committee is deeply concerned over the possibility of calling up physicians in Priority III over 31 years of age to meet military needs for fiscal 1955. The purpose of the procedure outlined below is to assist in avoiding that possibility since many of the older group are in well-established practices and are more essential to hospitals and medical schools.

If you already have the Priorities I, II and III under 32 tabbed with up-to-date classifications (since the hospital year is now over) it will, of course, not be necessary to undertake this program.

It is suggested that ODM Form 101 which lists the interns and residents in each hospital as of the last hospital year might be useful as a basis for providing a check list of the individuals referred to above. Therefore you should refer to your copies of this form and check those individuals whose names appear on these lists who are not—

(1) Female
(2) Aliens
(3) Priority IV
(4) In Priority III and over 31 years of age

to determine whether they are:

(1) On active duty
(2) Commissioned
(3) Have applied for commissions
(4) Still classified II-A
(5) Or classified in I-A

If this office can assist you in any way in this undertaking or if there are schedules which you do not have, please do not hesitate to let us know and we will supply you with the needed data.

It is hoped you will institute this program as soon as possible and, within the limits of the clerical help available to you, continue until it is completed.

Your cooperation will be greatly appreciated.

Obstetrics and Gynecology Examination Notice

Applications for certification (American Board of Obstetrics and Gynecology) for the 1955 Part I Examinations are now being accepted. Candidates are urged to make such application not later than August.

Application for examination or re-examination, as well as requests for resubmission of case abstracts, must be made to the Secretary prior to October 1, 1954.

Under a change of requirements for the Part I Examination, candidates must submit 20 case abstracts rather than 25 as formerly. Five of these may be from one's residency service.

Additional information may be obtained from Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6, Ohio, Secretary, American Board of Obstetrics and Gynecology.

Wayne Hospital, of Greenville, has been donated $300,000 for a new addition by Major William H. Henderson, 83-year-old Greenville native whose home is now Reno, Nev.

General Practice Scientific Assembly . . .

Two-Day Annual Session Is Scheduled in Columbus, September 22-23 By the Ohio Academy of General Practice; All Physicians Are Invited

THE Fourth Annual Scientific Assembly of the Ohio Academy of General Practice will be held on Wednesday and Thursday, September 22-23, in the Deshler-Hilton Hotel, Columbus.

The House of Delegates will convene on Tuesday, September 21.

Technical Exhibits by leading pharmaceutical, surgical instrument companies and other supply houses will be a part of the overall program.

A luncheon for the ladies has been arranged in the Ionian Room of the Deshler-Hilton for 12:30 p. m., Wednesday, with the Academy as host. Other entertainment features for the ladies is being arranged.

Registration booth will be open beginning at 8:00 a. m. on Wednesday, September 22, in the hotel Foyer. Hotel reservations should be made directly with the hotel of choice.

A cordial invitation is extended to all members and friends of the medical profession.

The scientific program has been announced as follows:

WEDNESDAY, SEPTEMBER 22

8:00 a. m.—Registration. **(All Time Is Eastern Standard)**

8:00—Visit Technical Exhibits.

9:00—Opening Annual Scientific Assembly.

Invocation.

Greetings from Ohio State Medical Association.

Greetings from Columbus Academy of Medicine.

Greetings from Franklin County Academy of General Practice.

Greetings from President, Ohio Academy of General Practice.

9:30—"Public Relations in General Practice," Dr. Richard C. Miller, Dayton.

10:00—"Medical Problems of the Athlete," Dr. John W. Wilce, Columbus.

10:30—Visit Technical Exhibits.

11:00—"Obstetrics in General Practice," Dr. Abe Kuhr, Dayton.

11:30—"Tuberculosis and the General Physician," Dr. I. Phillip Frohman, Washington, D. C.

12:00 noon—Lunch Period and Visit to Technical Exhibits.

1:30 p. m.—"The Patient with a Headache," Dr. Howard D. Fabing, Cincinnati.

2:00—"Poliomyelitis Immunization," Dr. S. R. Robbins, Cleveland.

2:30—"Multiple Sclerosis and Progressive Muscular Dystrophy," Dr. Dwight M. Palmer, Columbus.

3:00—Visit Technical Exhibits.

3:30—"Medical Education," Dr. Stanley C. Dorst, Cincinnati.

4:00—"The General Physician and the Hospital," Dr. Frank C. Sutton, Dayton.

4:30—Visit Technical Exhibits.

6:00—Social Hour and Banquet.

Toastmaster, Dr. A. R. Marsicano, Columbus.

"The Human Side of Medicine," Dr. Leo H. Bartemeier, Detroit.

Entertainment and Dancing.

THURSDAY, SEPTEMBER 23

8:00 a. m.—Visit Technical Exhibits. **(All Time Is Eastern Standard).**

9:00—"Newer Therapeutic Methods in Dermatology," Dr. Roy L. Kile, Cincinnati.

9:30—"Therapeutic Nuggets," Dr. Oscar F. Rosenow, Columbus.

10:00—"The Problem of Narcotic Enforcement," Mr. Ross B. Ellis, Detroit.

10:30—Visit Technical Exhibits.

11:00—"Hearing Impairment in Children," Dr. Charles E. Kinney, Cleveland.

11:30—"Cervical Disc, Shoulder, Arm, Hand Syndrome," Dr. Winchell Craig, Mayo Clinic, Rochester, Minn.

12:00 noon—Adjournment.

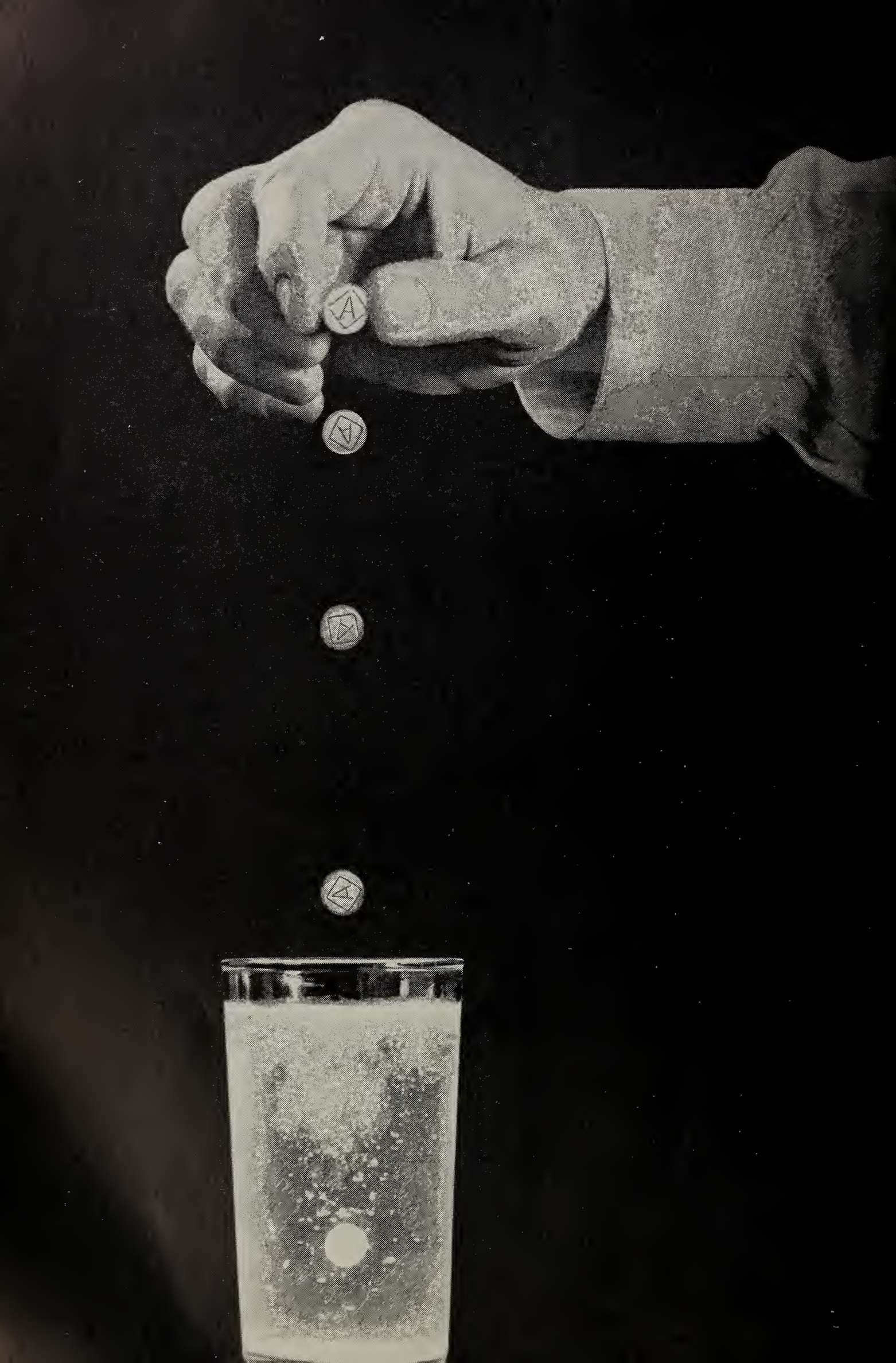
Trumbull County Medical Society Has Positive PR Program

An example of a positive Public Relations program is that of the Trumbull County Medical Society which has established an emergency call service and has organized a well-rounded program for examination for children's groups.

More than 700 pre-school children have been examined. Members of the Society also examined all boys and girls for camps including the Y. M. C. A., Camp Fire Girls, and checked the Boy Scouts and Girl Scouts on arrival at camp.

In April the Society established an Emergency Call System, arranging with the Telephone Secretary Company to take calls. The Society has its own telephone and an exclusive telephone number for twenty-four hour answering service. The Society also ran a series of 10 announcements in the local newspaper advising the public of the service offered by the doctors of the community.

The Society also is planning an extensive Health Exhibit as part of the Trumbull County Fair in early August.



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filmtab* Erythrocin®

starts to dissolve

NEW filmtab* ...for faster drug absorption

Now, *there's no delayed action from an enteric coating.* The new tissue-thin *Filmtab* coating (marketed only by Abbott) starts to disintegrate within 30 seconds after your patient swallows it—makes the antibiotic available for immediate absorption.

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Because of the swift absorption, your patient gets high blood levels of ERYTHROCIN (Erythromycin Stearate, Abbott) in *less than 2 hours*—instead of 4-6 hours as before. Peak concentration is reached within 4 hours, with significant concentrations lasting for 8 hours.

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It's easy on them. Compared with most other widely-used antibiotics, *Filmtab* ERYTHROCIN is *less likely to alter normal intestinal flora.* Prescribe *Filmtab* ERYTHROCIN for all susceptible coccic infections—especially when the organism is resistant to other antibiotics. Bottles of 25 and 100 (100 and 200 mg.).

Abbott

**TM for Abbott's film sealed tablets, pat. applied for*

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A Quarter of a Million

PUBLIC RELATIONS LEAFLETS

Have Been Ordered by Ohio Doctors

These leaflets cover these subjects:

"QUACK"—warns public about quack healers
"HEALTH TODAY"—outlines progress made by medicine
"ON GUARD"—how the A. M. A. evaluates drugs
"WHY WAIT?"—best ways to select a family doctor

Especially adapted for doctors' waiting rooms, county fair distribution, public gatherings, and for mail enclosures.

You can get your supply now, without charge by mailing a card or letter to:

Ohio State Medical Association,
79 E. State St., Columbus 15, Ohio

Don't forget to tell us how many of each . . . and include your name and address

Three Ohioans Honored at Meeting of Women's Medical Association

Two Ohio physicians were elected to high offices in the American Medical Women's Association, and two were named to head national committees, when the organization met in San Francisco, June 18-21.

Dr. Esther Marting, Cincinnati, was named president-elect.

Dr. Edith Petrie Brown, Bedford, was named second vice-president and also was named chairman of the standing Committee on Organization and Membership.

Dr. Mabel Gardner, Middletown, a past-president of the organization, was awarded the highest honor of the American Medical Women's Association by being presented the Blackwell Award, for outstanding service by a woman to medicine. Dr. Gardner also was named chairman of the standing Library Committee.

The American Medical Women's Association has established as one of its major objectives the aid and encouragement of women medical students. For the second consecutive year it has presented a cash award of $100 and an Award Achievement Citation to each woman who graduated as the top ranking student in her class from the 71 approved medical schools in the United States. Seven women graduated this year leading their classes scholastically.

O. S. U. Directs Residency Training At Dayton V. A. Center

The residency training program at the Dayton Veterans Administration Center is under direction of the Ohio State University College of Medicine, effective July 1. For the past several years it has been under jurisdiction of the University of Cincinnati College of Medicine.

Dr. Charles A. Doan, dean of the O. S. U. College of Medicine, is chairman of the new dean's committee. Other members include Dr. Emmerich von Haam, professor of pathology; Dr. Robert Zollinger, professor of surgery; Dr. B. K. Wiseman, professor of medicine.

The retiring committee consisted of Dr. Stanley Dorst, dean of the Cincinnati College of Medicine; Dr. Edward A. Gall, Dr. William Altemeier. and Dr. Marion Blankenhorn.

Western Reserve Gets Large Polio Grant for Rehabilitation

A $230,000 grant has been given to Western Reserve University by the National Foundation for Infantile Paralysis for rehabilitation purposes. Although emphasis is placed on use for polio patients, rehabilitation will be afforded to all patients who can be benefitted. Dr. William S. Clark, assistant professor of medicine, will head the program.

Simplified Insurance Form . . .

Cleveland Academy of Medicine Committee Drafts Document For Use of Members and Makes It Available in Quantities at Nominal Charge

THE Cleveland Academy of Medicine provides its members with a supply of the following blank for submitting information to insurance companies, at a cost of 50 cents per pad of 50 blanks. It was formulated by an Academy committee. Note the stipulation that an additional charge will be made for completing any additional form. Other societies might consider this project for their members.

Certificate of Proof of: { ILLNESS / INJURY / DEATH

*Submitted in lieu of your form No. _____

To _____

Name _____

Address _____
STREET TOWN STATE

Age _____ Sex _____ Legal Status _____ Color _____ Occupation _____

Date of first visit _____ Date of last visit _____

Place of first visit _____ Place of last visit _____

Diagnosis _____

Method of Confirmation _____

Hospitalized _____ Yes or No _____ Name of Hospital _____

Date Admitted _____

Date Discharged _____

Total fee charged for this condition $ _____

Operation _____ Date _____

Probable onset of symptoms from this condition _____

Disability to My Knowledge:

Total: From _____ To _____

Partial: From _____ To _____

Is condition related to any other systemic illness? If so specify:

Is condition covered by Workmen's Compensation? _____

Name of Doctor _____

Address of Doctor _____

Date of Report _____

Authorization from patient:

I hereby authorize the use of the enclosed information for insurance purposes.

Signed _____

*An additional charge will be made to the insurance company for the clerical cost of completing any additional forms.

(This form supplied by the Academy of Medicine of Cleveland)

IMPORTANT ANNOUNCEMENT

FOURTH ANNUAL SCIENTIFIC ASSEMBLY

of the

OHIO ACADEMY OF GENERAL PRACTICE

TUESDAY-THURSDAY, SEPTEMBER 21-23, 1954

DESHLER-HILTON HOTEL, COLUMBUS, OHIO

House of Delegates convenes Tuesday, September 21st
Scientific Program opens at 9:00 A.M. (EST) Wednesday,
September 22nd—closes at 1:00 P.M. (EST) Thursday, September 23rd

Technical Exhibits *Special Entertainment for the Ladies*

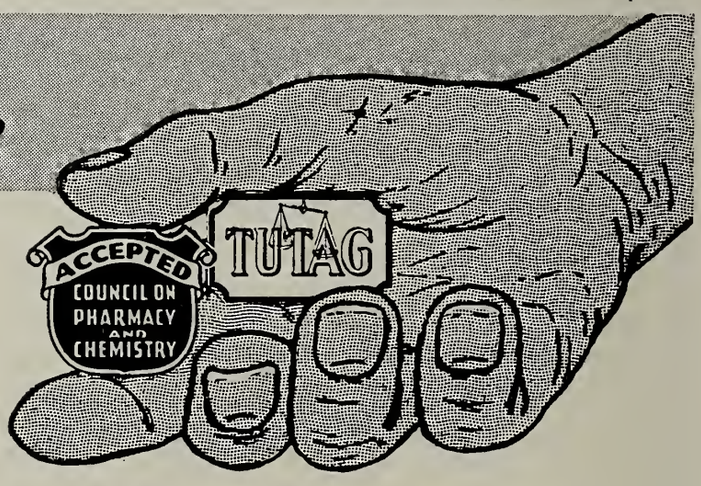
Banquet, guest speaker, entertainment, dancing, Wednesday Evening,
September 22nd — Banquet Ticket Reservation
Registration 8:00 A.M. (EST) September 22nd

Make Hotel Reservations directly with Deshler-Hilton Hotel

If further information is desired write or telephone

OHIO ACADEMY OF GENERAL PRACTICE
Room 407-410, 209 South High Street
Columbus 15, Ohio
Telephone: CApital 4-8681

Seals of Quality . . . Guarantee the Finest!



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- Buffonamide (Acet-Dia-Mer Sulfonamides)
- Mannitol Hexanitrate
- Aminophylline
- Testosterone Propionate

Yes doctor, these products now bear the A.M.A. Seal of Acceptance in addition to the familiar Tutag trademark which has also become a symbol of quality during the past decade. These outstanding pharmaceuticals are internationally distributed and are ethically promoted in the leading medical journals.

You can prescribe or dispense Tutag Pharmaceuticals with the utmost of confidence. Let us prove to you that fine pharmaceuticals can be economically produced for you and your patients.

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You and Your Public . . .

County Professional Relations Committees Enumerate Some of their Experiences in Relations Between the Patient and the Doctor

A NEW public relations feature appearing in *The Bulletin* of the Academy of Medicine of Toledo and Lucas County, is the publication of experiences of the Academy's Professional Relations Committee, describing situations which have caused poor relations between the doctor and the patient.

Written by a former member of the committee, the reports are published so that such situations may be avoided by others.

The first of the series of reports published in the June issue of *The Bulletin*, follows:

Mr. A. had a son who sustained a severe face laceration. Mr. A. took his son to a local hospital and called Dr. B. his family physician. Dr. B. advised that Dr. C. a surgeon, be called to take care of the patient. Because of the location of the laceration and the youth of the patient, Dr. C. decided a general anesthetic would be necessary. He called Dr. O. an anesthetist, who gave the anesthetic using endotracheal intubation in order to administer a safe anesthesia.

The operation was entirely successful. Mr. A. and his wife were happy until they received their bills. They first called Dr. B. about the surgeon's and anesthetist's fees. His short answer to Mr. A. was "there is nothing I can do about it."

In desperation Mr. A. called the anesthetist Dr. O. His nurse curtly informed the patient that this was a standard fee in Toledo for the service rendered. She would not permit Mr. A. to talk to Dr. O. as he was too busy.

Mr. A. then called his family doctor, Dr. B., who in disgust told the patient to file a complaint with the PR Committee of the Academy. This was done.

After careful investigation by the PR Committee it was learned that the fees were not excessive. Mr. A. was informed and a member of the Committee *took time* to explain what was involved in repairing a severe laceration of the face, and in giving a proper anesthetic with the skill necessary for intubation. He was also told that if there was hardship involved all three doctors had volunteered to adjust their fees accordingly.

What caused the trouble in this case?

1. Bills that seemed moderate to the three doctors appeared to be a lot of money to a man with a family to raise on a $50.00 per week salary.

2. The lack of insight by the family physician Dr. B. who failed to take a few minutes to explain the reason for the amount of the fees.

3. The smugness and thoughtlessness of the office nurse who in an authoritative manner would not let the patient and anesthetist discuss the bill.

In the final result, the father paid the bills and was satisfied that he had received his money's worth. However, the mental conflict in this case did nothing to enhance the public relations of the medical profession.

ADVICE FROM NEW YORK

Issued as the report of one of the county medical society mediation committees in New York is a list of eight lessons learned in connection with the pursuit of its duties. A capsule review of the "lessons," as published in the February issue of the Newsletter of the Medical Society of the State of New York, follows:

Physicians should:

1. Supervise billings from their offices;
2. Tell patient explicitly before treatment where poor end results are unavoidable or where condition may recur and that charges will be made for second procedure, if necessary.
3. Be alerted to activities of clerical help in collecting bills, by phone or mail;
4. Leave instructions to be notified before office help place bills in legal hands for collection;
5. Realize that out-of-town collection agencies are a detriment in mediating a medical problem, especially one involving an old bill;
6. Give receipted bills when bills are paid and instruct patients to keep same;
7. Keep accounts very carefully. Make exact computations and list correct dates;
8. Seek an early solution to fee problems by contacting the patient personally, by phone or by mail.

Apropos of the above "lessons," doctors are reminded that the A. M. A. has sent to all members a 68-page public relations manual entitled "The Human Side of Medical Practice." Booklet contains numerous practical suggestions for improving doctor-patient relations as well as office practice procedures.

More help to societies producing local television shows are the first two in the series of script clips which A. M. A.'s Bureau of Health Education currently is offering on a loan basis. It consists of a script which can be narrated by a local physician and an accompanying film to illustrate the script.

accuracy every time

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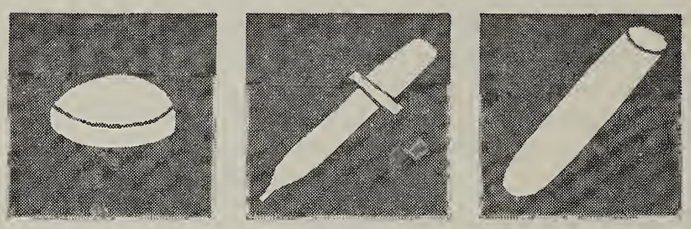
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"Both *Clinitest* and Benedict's qualitative test are completely accurate when properly performed."[1]

but

"...there are fewer sources of error with *Clinitest*."[1]



and

"The routine Benedict test...is seldom well performed because of the difficulties of accurate measurement of reagent and urine and because of the practical difficulties of uniform heating; the much simpler and more readily standardized tablet test is to be preferred..."[2]



1. Cook, M. H.; Free, A. H., and Giordano, A. S.: Am. J. M. Technol. *19*:283, 1953.
2. Gray, C. H., and Millar, H. R.: Brit. M. J. *4824*:1361 (June 20) 1953.

Ames Diagnostics—Adjuncts in clinical management

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Ames Company of Canada, Ltd., Toronto

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In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

POSSIBLE HEALTH LEGISLATION IN 1955

Before he left the State Department of Health to become head of the new State Department on Mental Hygiene and Correction, Dr. John D. Porterfield addressed the Ohio Citizens Council on Health and Welfare.

During his remarks, Dr. Porterfield stated that he had been doing some thinking about the next session of the Ohio General Assembly (1955). He indicated that the following might be the "legislative concerns" of the Ohio Department of Health in 1955:

1. Full state financial support—present $1.3M —$1.9 M/annum puts Department on 100 per cent State basis—varying Federal funds to local unit support and demonstration.
2. Adequate housing for required operations (O. D. H. operations—laboratory, x-ray reading, education, radiation studies) calls for specialized space; perhaps a "health services building" with Department of Mental Health and Corrections.
3. Comprehensive meat and milk sanitation control—in appropriate coordination with other aspects.
4. Integration of program for standards and licensing all types of medical care facilities.
5. Better integration of public health and mental health programs. (This may be operational—not legislative).
6. Competitive classification—compensation for trained public health personnel.
7. Authorization and funds for in-service training program.
8. Authorization and funds to enter atmospheric pollution and radiation control fields.
9. Clarification of responsibilities of Industrial Commission, Department of Industrial Relations and Health Department in occupational health program. (Not necessarily legislative.)

It may be that most, if not all, of these suggestions will be before the Legislature in 1955 in the form of bills. Those interested should be giving them some thought prior to January 1.

TOO MANY TIMES PROMOTERS GET ALL THE BENEFITS

There are just about as many fund raising organizations as there are ideas, these days. Many of them get into the medical-health field. Some are worthy projects. Some are questionable. Some are just plain frauds.

Physicians many times are asked for advice on this organization or that fund raising venture with medicine or health as a theme song. If they are not dead sure about the organization, they should advise those inquiring to get the facts before giving. Better yet, they might call the Better Business Bureau or some similar investigating body.

An example of projects which fatten promoters in the name of unfortunates they appear to aid, but don't, is the following comment which appeared in the June issue of the Columbus Better Business Bureau publication, *For the Home Folks*:

"A report from the Milwaukee BBB states that out of a total of $762,000 in contributions over a two-and-one-half-year period, the National Foundation for Asthmatic Children received only $8,650. This information was disclosed when the Foundation had sought a license for its Brandes school in Tucson, Arizona.

"An audit of the foundation's books indicated that the bulk of the funds collected came through the efforts of two fund raising organizations in Chicago. However, it has been stressed that no illegal activities have been uncovered in the fund raising."

PRESCRIPTION FOR GOOD PUBLIC RELATIONS PROGRAM

The Public Relations Director of a large corporation in a recent address made some mighty pertinent comments about the attitude which management should take on the duties of its P. R. director and what it expects of him.

What he said applies equally as well to a medical society which has a public relations director or a public relations committee. The advice which he gave, as follows, is something which every medical society should digest carefully:

"The problems of Public Relations are seldom waves of majority opinion which arise overnight. They are little clusters of gripes and misunderstandings here and there which labor incessantly to convert minority opinion into majority. The time to meet these problems is at the 'cluster stage'—and the time and money to be expended on them should be determined not by their present size, but their potential.

"You are not making the best use of your Public Relations director when you employ him to answer attacks and criticism. You are obtaining the full value of his skill and experience only when you use him to keep as many such criticisms as possible from ever arising.

"The best Public Relations is aggressive, not defensive. It is positive, not negative. It is truth, not subterfuge. It is deeds accomplished and described, not convincing words alone.

"When you have been inoculated with this painless prescription, Mr. Management, you may find that your Public Relations director or counsel does not measure up to the tremendous assignment that is his. But, it is much more likely that you will discover that your current Public Relations specialist can contribute much more to

your own wealth and welfare than you had ever thought possible.

"If this be true, give him his head—and a budget of prerogative and money large enough to do the job."

THREE CLASSES OF OFFENDERS ON HOSPITAL STAFFS

With the hospital bed situation what it is—tight—physicians should be considerate and cooperative in helping their hospital to meet the ensuing problems. They should avoid admitting patients on an emergency basis where no emergency exists; scheduling operations again where no true emergency exists; disregarding the call system, etc.

Commenting on these shortcomings, the president of one County Medical Society recently chided members of the society, mildly, as follows:

"In my opinion the majortiy of offenders fall into one of three categories. These are: (1) The Eager Beaver; (2) The Hell and High Water Individual; (3) The Thoughtless Soul.

"I heard of the first person in World War II. This term appears to have originated in the Air Corps and later spread to the Army and Navy. It usually referred to a newcomer—a recruit or a newly made officer who is overly ambitious —the 'new broom sweeps clean' type. Usually if they survive this period they make a good adjustment although once in a while they grow into phase two or three.

"The second character is made of sterner stuff. He is going to have his patient seen come Hell and High Water. If it means cutting in on some one, that's all right as his patients are always more important than his colleagues'. So it's extremely easy to justify to himself his rather ruthless behavior.

"The Thoughtless Soul, like Jackie Gleason's, The Poor Soul, goes thru life in rather a daze. He steps on others toes as he blunders along. He honestly does not realize that he harms anyone as he goes on his inoffensive way."

It might be well to take stock and see if we fall in any of the above groups.

A PROBLEM IN EXPERT MEDICAL TESTIMONY

In a decision not too long ago on a Workmen's Compensation case, the judge of one of Ohio's Common Pleas Courts, did a rather neat job of pointing out that some of the so-called expert opinion being presented in court by some physicians is more confusing than helpful, and that, at times, some of the medical experts draw such a long bow that "it causes one inevitably to wonder just how much of what is said is really believed by the witness."

Lawyers for the plaintiff were endeavoring to prove that a pre-existing condition had been aggravated or accelerated by an alleged injury. Two physicians testified as experts. As to their testimony the court said:

"Both physicians undertook to explain rather laboriously how such pre-existing condition would be affected by an assumed traumatic injury, but from each of their own examinations they knew full well that the claimant was not in good physical condition on or before March 18, 1949, although asked to assume that he was 'in good condition' at that time. . . . .

"It can be said frankly that it is often extremely difficult to rationalize the fantastic labyrinth of explanation by which some medical opinions are arrived at and it causes one inevitably to wonder just how much of what is said is really believed by the witness."

Continuing, the court observed:

"An appeal to the courts from a decision of the Industrial Commission adverse to a claim for participation in the Workmen's Compensation Fund was never intended as an open sesame to free-handed gratuity at the expense of the legitimate rights of those workmen who are properly entitled to its benefits or of the contributors thereto. Nor was it intended as a game of chance in which expert medical opinion too often lends itself to highly speculative impulses seemingly designed to baffle, dominate and outwit lay juries."

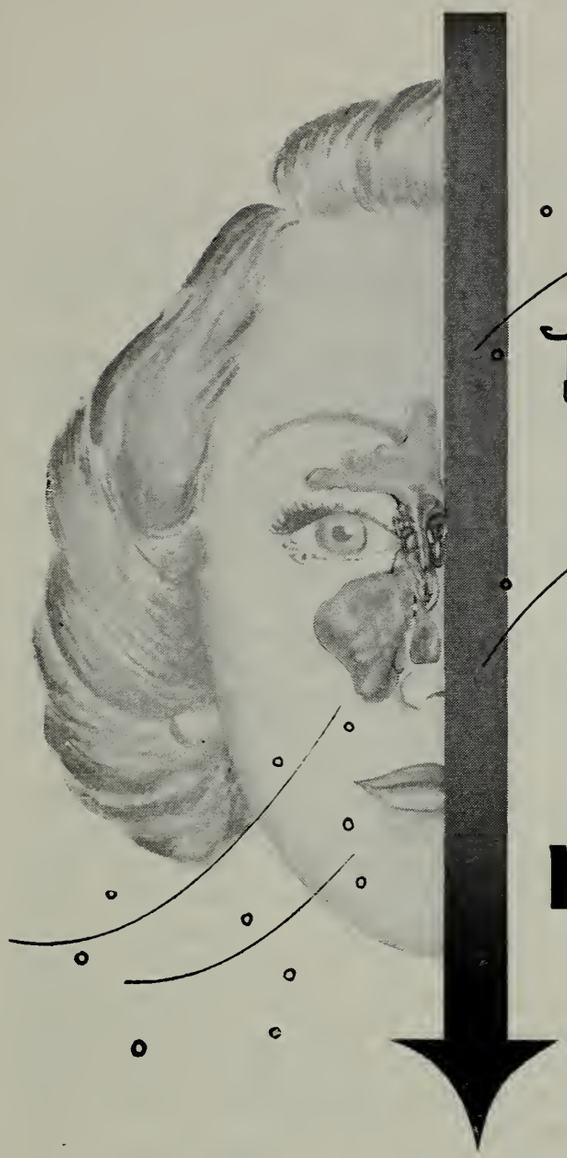
It is extremely unfortunate that an Ohio court found it necessary to issue such a rebuke. Expert medical opinion is highly essential in many, many types of litigation. Day after day, many well qualified physicians appear in court to present essential, helpful and honest medical opinion. However, the tactics of a few physicians cast a shadow on the reputation of all physicians and cause courts and others to question the reliability of the testimony of all doctors.

Perhaps it is high time that medical societies ask their committees on ethics to devote some intensive study to this question. Questionable cases appear to be increasing. The sooner something stringent is done to stop this trend, the better.

Moreover, the matter should be considered by bar associations, as the medical expert probably wouldn't be on the stand unless a lawyer arranged for his appearance.

Urological Award

The American Urological Association is again offering an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in Urology. For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 1, 1955.



To open congested air passages in hay fever

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. . . reduces nasal engorgement . . .

promotes aeration . . . encourages drainage

A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

The resultant relief to the hay fever sufferer is decidedly gratifying. Prolonged action of Neo-Synephrine makes fewer applications necessary, consequently longer periods of rest and sleep are possible.

Neo-Synephrine does not lose its effectiveness on repeated application and may, therefore, be relied upon to give relief throughout the hay fever season.

Neo-Synephrine is practically free from sting and compensatory congestion; does not appreciably inhibit ciliary activity. Neo-Synephrine has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

0.25% Solution (plain and aromatic)

0.5% Solution; 0.25% Spray (unbreakable plastic squeeze bottle)

1% Solution

0.5% water soluble Jelly

1. Van Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

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Neo-Synephrine, trademark reg. U.S. Pat. Off., brand of phenylephrine.

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

To prevent duplication of Federal efforts in policing the food, drug, and cosmetic industries, the Federal Trade Commission and the Food and Drug Administration have agreed to appoint liaison officers to serve as primary points of contact between the two groups. The agencies also agreed that the F. T. C. would exercise sole jurisdiction over cases relating to truth in advertising of foods, drugs, devices and cosmetics. The F. D. A. will exercise sole authority over all matters relating to the labeling of foods, drugs, devices and cosmetics.

* * *

The Department of Health, Education, and Welfare estimates that through April 30, 238 security risks had been fired or resigned under the President's loyalty program. Of these, 114 were suspected of various degrees of subversive activity, subversive association, or membership in subversive organizations.

* * *

A Federal Trade Commission order prohibits exaggerated advertising claims for "Dahlberg Tru-Sonic Canal Earphone." Dahlberg Co., of Minneapolis, consented to order, which bars representations that the device has been accepted by the A. M. A.; that it is out of sight when inserted in the ear canal, and that it will fit any wearer.

* * *

Commission on Intergovernmental Relations has named a 13-member study group, headed by Dr. Franklin D. Murphy, chancellor, and former dean of medicine, University of Kansas, to investigate Federal grants to state and local governments for public health and hospital projects. Dr. Edward J. McCormick, Toledo, past-president of the American Medical Association, is a member of the committee.

* * *

On and after September 29, dietary foods represented to be of low salt or low sodium content will have to bear labels indicating sodium content per 100 grams of food, and amount of sodium contained in an average serving. This is in accordance with a Federal Food and Drug Advertising regulation.

Federal Civil Defense Administration headquarters will be shifted from Washington to Battle Creek, Michigan, September 1.

* * *

Accident and health insurance industries have established a Washington office. In charge is Robert R. Neal.

* * *

Major General Dan C. Ogle succeeds Major General Harry G. Armstrong as Surgeon General of the Air Force. Gen. Armstrong has been assigned as Surgeon of the U. S. Forces in Europe.

* * *

Just published by the U. S. Public Health Service is a 247-page reference work on nationwide distribution of medical, dental and paramedical personnel. Data are presented by counties, in tabular form, on 16 occupations. Of a total of 1,327,674 persons so engaged in 1950, 398,534 were professional nurses. Physicians and surgeons numbered 191,947, or 127 per 100,000 population; dentists, 74,855, or fifty per 100,000 population; practical nurses, 135,902 and pharmacists, 88,116.

The book is U. S. P. H. S. Publication No. 263, Sec. 4, available for $1.75 from Superintendent of Documents, Washington 25, D. C.

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since June 10, 1954. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY
Robert J. Roehm, Lakewood
Vernon Rowland, Cleveland

ERIE COUNTY
Eugene J. Martos, Sandusky

LUCAS COUNTY
Raymond J. Dittrich, Toledo
William J. Marinis, Toledo
Homer F. Schroeder, Toledo

MAHONING COUNTY
James L. Calvin, Youngstown

MEIGS COUNTY
Alfreds Smits, Middleport

MUSKINGUM COUNTY
Roman Matwijeko, Dresden

ROSS COUNTY
John W. Franklin, Jr., Chillicothe

ALEXANDER MACK, M.D.
Medical Director

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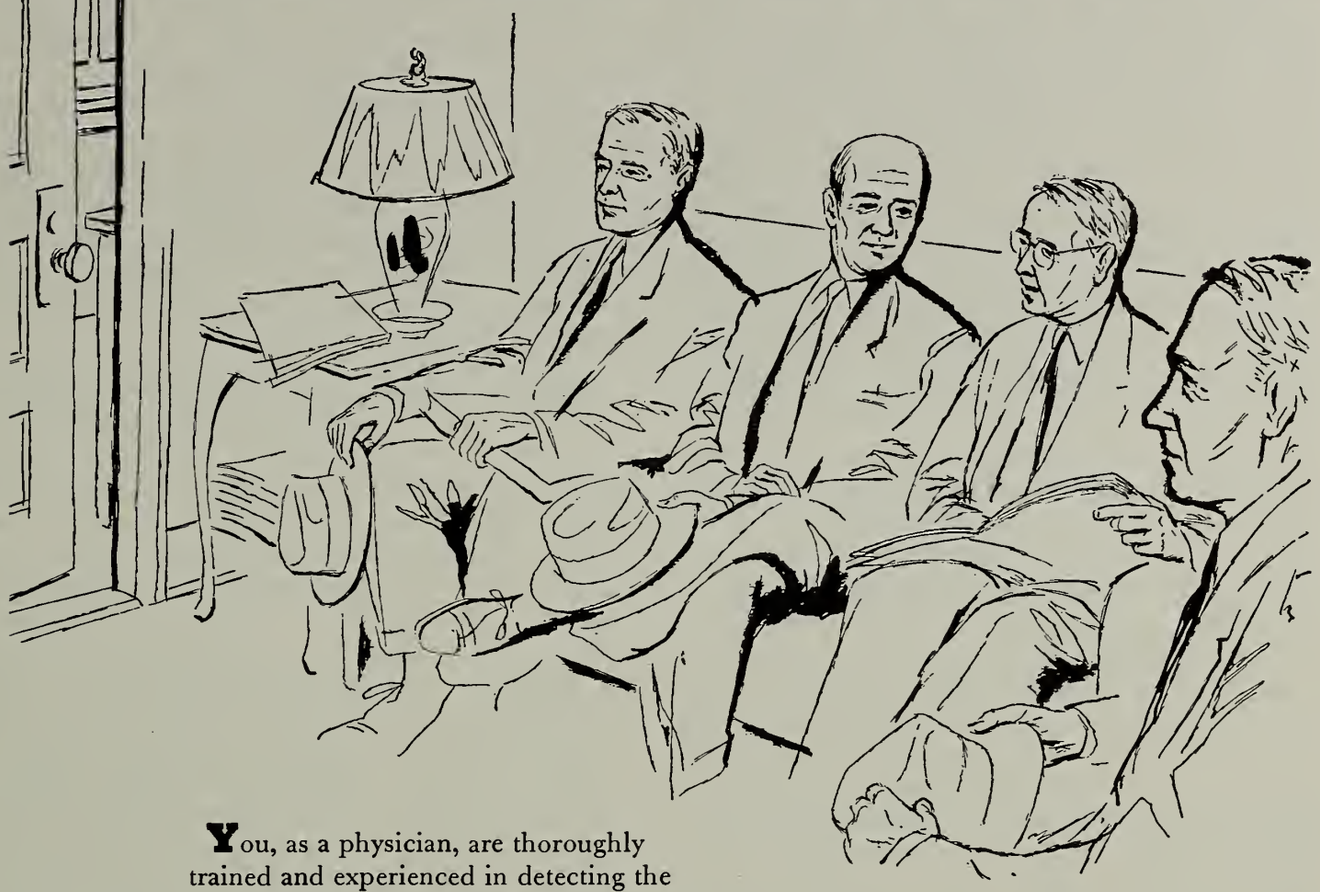
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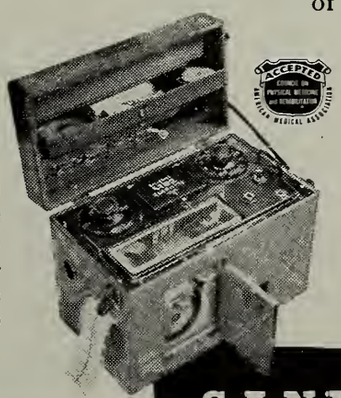


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In Memoriam . . .

Arthur Baer, M. D., Cleveland; medical degree from Kaiser-Wilhelms University, Germany, 1905; aged 74; died April 17; member of the Ohio State Medical Association; member of the American Medical Association. Retired in recent years, Dr. Baer had been a practicing physician for many years in the Cleveland area. His widow survives.

Hugh A. Baldwin, M. D., Columbus; Jefferson Medical College, 1901; aged 75; died June 14; member of the Ohio State Medical Association and member of the American Medical Association; Fellow of the American College of Surgeons; member of the American Urological Association and the Radiological Society of North America; diplomate of the American Board of Urology. Dr. Baldwin served all of his professional career in Columbus, following in the footsteps of his father, the late Dr. J. F. Baldwin. He was honored two years ago by the Columbus Academy of Medicine by being presented the 50-Year Pin of the Ohio State Medical Association. Dr. Baldwin was chief of staff, head of the x-ray department and chairman of the board of trustees of Grant Hospital. He was a member of the Congregational Church, the Masonic Order, Phi Psi and Rocky Fork Country Club. Survivors include his widow, a brother, two sisters and two half sisters.

Henry Ernest Blass, M. D., Akron; medical degree from Heidelberg University, Germany, 1921; aged 64; died June 19; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Dermatology and Syphilology, and diplomate of the American Board of Dermatology and Syphilology. Dr. Blass came to the United States in 1924, took residency work in Akron and continued to practice there. He was a member of the Masonic Lodge. Surviving are his widow and a daughter.

Martin Calvary, M. D., Warren; Ludwig-Maximilians University, Germany, 1907; aged 69; died June 13; member of the Ohio State Medical Association and the American Medical Association. Dr. Calvary came to this country in 1938 and began practice in Warren after a year's residency in Cincinnati. He was a member of the Beth Israel Congregation, B'nai B'rith, the Zionist Organization, the Warren Civic Music Association and the Warren Community Forum. He is survived by his widow, a daughter, a son and a brother.

Walden Allen Clark, M. D., Pittsburgh, Pa.; Starling Medical College, Columbus, 1900; aged 76; died June 10. Dr. Clark moved to Pennsylvania upon completion of his medical training in Columbus.

Orlando E. Cress, M. D., Van Wert; Eclectic Medical College, Cincinnati, 1921; aged 65; died June 20; member of the Ohio State Medical Association and the American Medical Association; vice-president of the Van Wert County Medical Society, 1947, and member of several local committees. Dr. Cress moved to Van Wert in 1931 after practicing at Cincinnati. He served in World War I and as a medical officer during World War II. Affiliations included membership in the American Legion and the Veterans of Foreign Wars. Surviving are two brothers, Dr. H. L. Cress, D. D. S., Van Wert; and Forrest V. Cress, M. D., of Cincinnati.

Howard Dittrick, M. D., Cleveland Heights; University of Toronto Faculty of Medicine, Canada, 1900; aged 77; died July 11; member of the Ohio State Medical Association and the American Medical Association; active on a number of committees of the Academy of Medicine of Cleveland, among them the Publications Committee, the Special Committee on Honors and the Special Anniversary Committee. A practicing physician for many years in Cleveland, Dr. Dittrick was widely known as a medical writer and historian. He was founder of the historical museum of the Cleveland Medical Library Association which in 1945 was named in his honor as the Howard Dittrick Museum of Historical Medicine. In 1943 Dr. Dittrick received the annual Distinguished Service Award of the Academy of Medicine of Cleveland. He was a constant contributor of articles for medical journals including many papers which appeared in *The Ohio State Medical Journal*. His books included *Pioneer Medicine in the Western Reserve* and *Important Contributions to Medicine by Clevelanders*. Also he was editor of the publication *Current Researches in Anesthesia and Analgesia*. He was a former professor of historical medicine at the Frank E. Bunts Educational Institute and on two occasions was a delegate at the International Congress of History of Medicine, when that organization met in Spain and in Yugoslavia. Dr. Dittrick was a member of the Cleveland Museum of Art and was chairman of the intermuseum advisory group in Cleveland. He was a charter member of the Pasteur Club and belonged to the Fowfant Club and other organizations. Survivors include his widow and six sons.

James R. Dowling, M. D., Massillon, Queen's University, Canada, 1929; aged 48; died June 3; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology and Oto-Laryngology; Fellow of the American College of Surgeons; diplomate of the American College of Surgeons. Dr. Dowling practiced medicine in Massillon for approximately 20 years. He was a member of the staffs at Mercy and Aultman

Hospitals in Canton and City Hospital in Massillon. Affiliations included memberships in the Catholic Church, the Holy Name Society, the Knights of Columbus, the Elks Lodge and the American Legion. Surviving are his widow, a son, two daughters, his mother and a sister.

Paul V. Duffy, M. D., Cleveland; Creighton University School of Medicine, Omaha, Neb., 1922; aged 57; died July 5; member of the Ohio State Medical Association and the American Medical Association through 1953; active on several committees of the Academy of Medicine of Cleveland; diplomate of the American Board of Obstetrics and Gynecology. Dr. Duffy practiced for 30 years in Cleveland where he was on the staffs of St. Ann's, St. Alexis' and Marymount Hospitals. His widow survives.

John Jesse Dunlap, M. D., Columbus; Physio Medical College, Indianapolis, 1896; aged 82; died June 11. Dr. Dunlap practiced in Fairfield, Pickaway and Franklin Counties before his retirement 13 years ago.

Henry J. Gerstenberger, M. D., Cleveland; Western Reserve University School of Medicine, 1906; aged 73; died June 24; member of the Ohio State Medical Association, the American Medical Association, the American Pediatric Society, the American Academy of Pediatrics and the American Public Health Association; diplomate of the American Board of Pediatrics. A native of Cleveland, Dr. Gerstenberger began his practice there in 1906. Formerly professor of pediatrics at Western Reserve University, he was later named professor emeritus. Instrumental in founding Babies' and Children's Hospital, he was its first director of pediatrics and also headed the pediatrics department at City Hospital. Active in several international professional groups, he headed the American delegation to the International Congress for Protection of Childhood in Rome in 1937. His widow and three daughters survive.

William Humphrey Hyde, M. D., Cleveland; University of Wooster, Medical College, Cleveland, 1896; aged 84; died June 9; member of the Ohio State Medical Association through 1947. A practicing physician in Cleveland for more than a half century, Dr. Hyde had received the 50-Year Pin of the Ohio State Medical Association. He was active in a number of Masonic bodies. Surviving are a son and a daughter.

Henry H. Lowe, M. D., Leesburg; University of Cincinnati College of Medicine, 1915; aged 64; died June 26; former member of the Ohio State Medical Association; president of the Highland County Medical Society at the time of death, also formerly president, vice-president and secretary of the Society and active as chairman or member of numerous local committees. Dr. Lowe served all of his professional career in Leesburg with time out only for service in the Medical Corps during World War I. He was chief of staff of the Greenfield Municipal Hospital, a member of the County Board of Education, a member of the Methodist Church, the Masonic Lodge and the American Legion. Surviving are his widow, his mother and a sister.

James D. McAfee, M. D., Cleveland; Cleveland University of Surgery and Medicine, 1891; aged 92; died June 26; former member of the Ohio State Medical Association, last in 1915; Dr. McAfee served all of his professional career in Cleveland where for many years he was president of the Board of Health. He was a member of the Masonic Order. Surviving are four sons.

Frank M. Natherson, M. D., Parma Heights; Ohio State University College of Medicine, 1934; aged 46; died June 19; member of the Ohio State Medical Association and the American Medical Association. Dr. Natherson served all of his professional career in the Cleveland vicinity, where he was on the staff of Deaconess Hospital. He was a member of the Masonic Order. Surviving are his widow, a son, a daughter, his parents and two brothers.

James Clyde Pugh, M. D., Beallsville; Eclectic Medical College, Cincinnati, 1921; aged 57; died June 13; member of the Ohio State Medical Association; member of the American Medical Association through 1953. A native of Monroe County, Dr. Pugh returned there upon completion of his medical training. He was a member of the Methodist Church, the Masonic Lodge, and the American Legion, being a veteran of World War I. Survivors include his widow and a daughter.

Raymond Clare Rush, M. D., Hudson; Cleveland-Pulte Medical College, 1901; aged 77; died June 24. Dr. Rush practiced for many years in Hudson and the vicinity. His widow, who resides in Willoughby, survives.

Waldo C. Suter, M. D., Waterville; Ohio State University College of Medicine, 1926; aged 60; died June 12; member of the Ohio State Medical Association and member of the American Medical Association through 1953; member of the American Academy of General Practice. After completion of a year's internship at University Hospital, Columbus, Dr. Suter opened his practice in Waterville. He was a member of the Presbyterian Church, and several Masonic bodies, and a past-president of the Rotary Club. Surviving are his widow, a daughter, two brothers and five sisters.

Isaac E. Williams, M. D., St. Marys; Kentucky School of Medicine, Louisville, 1892; aged 87; died July 3; member of the Ohio State Medical Association through 1946. Dr. Williams moved to St.

Marys about the turn of the century after practicing a short time in Wapakoneta. He had received the 50-Year Pin of the Ohio State Medical Association. A practitioner for more than 60 years, he was a recipient of the Ohio State Medical Association 50-Year Pin. Affiliations included membership in the Odd Fellows Lodge. Surviving are his widow, a son and a daughter.

Joseph H. Wolfe, M. D., Iowa City, Iowa; Ohio State University College of Medicine, 1910; aged 71; died June 12. Dr. Wolfe left Ohio early in his career to practice in Iowa.

Cytology Council

The second annual meeting of the Inter-Society Cytology Council will be held in the Statler Hotel, Boston, Mass., November 12 and 13. Additional information may be obtained from the Secretary-Treasurer, Inter-Society Cytology Council, 634 North Grand Blvd., St. Louis, Mo.

Occupational Therapy Meeting

The 37th Annual Conference of the American Occupational Therapy Association will be held at the Shoreham Hotel, Washington, D. C., October 16-22. Additional information may be obtained from the home office, 33 W. 42nd St., New York 36, N. Y.

Ohio Physicians Certified by Board Of Obstetrics and Gynecology

The following Ohio physicians were certified by the American Board of Obstetrics and Gynecology at the May 17 meeting in Chicago, according to information furnished by Dr. Robert L. Faulkner, Cleveland, secretary of the Board:

Drs. Bernard S. Abrams, Cleveland; Emerson B. Beery, Euclid; Charles V. Bowen, Akron; Louis D. Chapin, Euclid; Russell P. Dreyer, Cleveland; Robert S. Ellison, Mansfield; Harry E. Ezell, Columbus; William R. Graf, Cincinnati; Paul W. Hanahan, Painesville; Robert E. Johnstone, Cincinnati; Paxton L. Jones, Youngstown; James J. Karam, Canton, John P. Lenahan, Cleveland; Anna G. Pierce, Canton; Dan O. Ratzloff, Cleveland, Thomas H. Redding, Cleveland.

Cerebral Palsy Grant

United Cerebral Palsy has presented a $9,000 grant to Dr. George H. Acheson, professor of pharmacology at the University of Cincinnati College of Medicine. Dr. Acheson's department will use the grant to continue its study of the response of certain nerve cells in the body to damage, in a long range effort to learn enough about nerves to understand their organization.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D., MIDDLETOWN)

ADAMS

Dr. Samuel J. Ellison was honored upon completion of a half century of service in the medical profession at the June 3 meeting of the Adams County Medical Society in Cherry Fork.

Dr. Ellison, a native of Adams County, graduated from Starling Medical College, Columbus, in 1904 and began practice in Harveysburg. In 1910, he went to South Dakota, but returned to Ohio in 1912 and has been practicing in West Union since.

One of the speakers for the occasion was Dr. Edwin H. Ellison, of the Department of Surgery, Ohio State University, who is a grandnephew. Another grandnephew, Dr. Charles K. Fergueson, a resident physician at Bethesda Hospital, Cincinnati, and Dr. Ellison's son, Dr. Robert Ellison, of Peebles, were present.

The 50-Year Pin of the Ohio State Medical Association was presented by Dr. Charles T. Atkinson, Middletown, Councilor for the First District. The emblem was pinned by Dr. Ellison's grandson.

On behalf of the local Medical Society, Dr. Samuel Clark, president, presented Dr. Ellison with a television set.

For the Scientific program, Dr. Ralph Carothers of Cincinnati gave a talk on "Colles Fractures," and Dr. Edwin H. Ellison, one on "Acute Pancreatitis."

CLERMONT

Dr. O. C. Davidson, Bethel, was honored upon completion of 50 years of service at the June meeting of the Clermont County Medical Society.

Dr. Charles T. Atkinson, Middletown, Councilor of the First District, gave the address of presentation of the 50-Year Pin from the Ohio State Medical Association. He gave the pin to Dr. F. M. Oxley, president of the local society, who pinned it on Dr. Davidson.

Two physicians were taken into membership. They are Dr. Donald K. Ebersold, Milford, and Dr. Richard D. Carr, Williamsburg. Another new doctor in the county is Dr. Albert Ryan, Batavia. He has taken over the practice of Dr. P. R. Dobert who has been recalled by the Navy.

WARREN

Members of the Warren County Medical Society met at the home of Dr. and Mrs. R. M. Brewer on June 25 for a basket supper and meeting. Families of physicians also attended. Guest speaker was Dr. Richard Schmidt, Cincinnati.

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

GREENE

Dr. William P. Montanus, Springfield, was guest speaker at the June 10 meeting of the Greene County Medical Society at the Greene Memorial Hospital, Xenia. His subject was "The Surgical Treatment of Diverticulitis in Its Complicated Stages."

MONTGOMERY

Election of Dr. Frank L. Shively, Jr., as the 107th president of the Montgomery County Medical Society was announced at the Society's Annual Meeting at the Wright-Patterson Officer's Club. Dr. Shively will serve as president in 1956 following a year as president-elect in 1955 during Dr. T. L. Light's administration.

Vice-president in 1955 will be Dr. H. R. Cammerer, currently Chairman of the Narcotic Committee and a former secretary of the Society.

The new secretary will be Dr. Mason S. Jones,



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now chairman of the Public Relations Committee and a former Chairman of the Pediatric Section, the Polio Committee and the School Health Committee.

Dr. J. M. Wilson was elected treasurer for 1955. He now serves as secretary of the Society.

Dr. H. D. Cassel, a past-president of the Medical Society, was re-elected to a 3-year term as Trustee.

Elected to a 5-year term as Delegate is Dr. Ned Shepard. Dr. C. L. Kagay will be alternate Delegate for the same term.

Dr. F. G. Barr and Dr. J. M. Dasher were named to the Clinic Committee.

Members of the Society were guests of Brig. General Edward J. Tracy for the Annual Meeting. A golf tournament in the afternoon was followed by dinner at the Officer's Club.

Dr. Richard C. Miller, President, presented a Citation for Meritorious Service to Dr. Gordon B. Munson at the evening meeting. Dr. Munson's services to the Society and the community in the field of Public Relations and School Health were named in the award.

Present officers of the Society will continue in office until January 1, 1955. They are Richard C. Miller, M. D., president; T. L. Light, M. D., president-elect; J. M. Wilson, M. D., secretary; J. M. Shaffer, M. D., treasurer; H. D. Cassel, M. D., trustee 1954; R. E. Zipf, M. D., trustee 1955; T. A. Weaver, M. D., trustee 1956; R. C. Austin, M. D., past-president; H. F. Koppe, M. D., chairman, past-presidents.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The Papanicolaou Program maintained at the headquarters of the Academy of Medicine of Toledo by a full-time secretary shows an increase of approximately 10,000 over the report of December, 1952. The total of 60 cancers first detected by this method, now are on file, an increase of 20 over the previous year. The report shows that as of December 31, 1953, a total of 38,835 examinations were made on 18,965 patients. A total of 480 physicians had participated, 358 of them from Toledo and 122 from the surrounding area.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

CUYAHOGA

At the annual meeting of the Board of Directors of the Academy of Medicine of Cleveland, Dr. George L. Sackett was elected president of the Academy for 1954-1955. Dr. Sackett served as vice-president during the past year.

Elected to serve with Dr. Sackett as vice-president and chairman of the Executive Committee was Dr. William J. Engel.

The Board named Dr. B. B. Sankey to succeed Dr. George R. Krause as secretary-treasurer.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

The June 15 meeting of the Mahoning County Medical Society was held at the Elks Club in Youngstown, with the following program features:

Dr. Ben C. Berg, Jr., "Radioactive Isotopes in Tumor Localization and Diagnosis."

Dr. Robert E. Hancock, "Simplified Concept of Peripheral-Vascular Disease."

Dr. James H. Quinn, Jr., "A Preliminary Report of a New Proposed Screening Test for Cancer."

Dr. Rocco Vernino, "Afibrinogenemia Occurring in Premature Separation of the Placenta."

Eighth District

(COUNCILOR: ROBERT S. MARTIN, M. D., ZANESVILLE)

MUSKINGUM

Sanitarians from the Zanesville and Muskingum County health departments met with the Muskingum County Medical Society on June 15 at the Zanesville Country Club. The group discussed food laws and meat, milk and restaurant inspections. Dr. Margaret O'Neil, county health commissioner and president of the Muskingum Society, presided at the meeting.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

WAYNE

Dr. O. P. Ulrich was the guest of his associates at Dunlap Hospital and a group of friends on June 10 when they met to honor completion of 50 years of practice. A reception was held in the home of Dr. and Mrs. R. F. Hecker, followed by dinner at the Smithville Inn. The group presented him with an anniversary cake and a gift in the form of a clock.

Dr. Ulrich, now president emeritus of Dunlap Hospital's staff, went to Orrville in April, 1913, after practicing three years in Illinois and six years in Iowa.

Mrs. Ulrich shared the honors with her husband. Their son, Dr. Robert Ulrich, of Toledo, was present.

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SURGICAL PATHOLOGY

A systemic series of lectures is presented covering the lesions encountered in the practice of surgery. These are illustrated with fresh material from the operating room, gross specimens from the museum and kodachrome and microprojected slides. The latest advances in blood grouping and transfusion reactions; didactic procedures, such as frozen sections, surgical biopsies, sponge biopsies, and aspiration of body fluid and secretions, are outlined.

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Activities of Woman's Auxiliary . . .

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CLARK

A buffet dinner party and dance was arranged by the Woman's Auxiliary to the Clark County Medical Society for the final social event of the year. Host and hostess for the occasion were Dr. and Mrs. J. Harold Shanklin of Grey Gables, W. Home Rd., Springfield. Mrs. T. M. Hayes and Mrs. D. J. Parsons headed the committee in charge of this event. The King Combo furnished the dance music.

DELAWARE

A picnic dinner at the Idle Ease Farm in Centerburg marked the last meeting of the year of the Woman's Auxiliary to the Delaware County Medical Society.

The Auxiliary voted to pledge $150 to the hospital building fund. Reports on the state meeting in Columbus were given by Mrs. Wray Davies and Mrs. F. M. Stratton. The new president, Mrs. James G. Parker, appointed her committees for the coming year.

Mrs. D. L. Gantt was hostess to the group.

HAMILTON

Mrs. Robert H. Kotte, retiring president of the Woman's Auxiliary to the Hamilton County Medical Society, and Mrs. Robert M. Woolford, newly elected president, were hostesses at a delightful luncheon which was given at Maketewah Country Club on May 27. The retiring officers and standing committee chairmen were present to assist the incoming officers and committee chairman in preparation of the year 1954-1955.

HURON

The Woman's Auxiliary to The Huron County Medical Society met in the home of Mrs. Charles Edel in Norwalk on May 14. A character sketch of Cabinet Member, Oveta Culp Hobby, given by Mrs. W. A. Drury, was informative and most interesting. Business details were brought up to date, this being the last meeting of the fiscal year. Those attending enjoyed a fine luncheon, picnic style. Mrs. A. H. Kimmel and Mrs. Robert Gill of Norwalk assisted as co-hostesses. Mrs. T. H. Smith was named to attend the National Auxiliary Convention as delegate in San Francisco in June.

The slate of officers for the past year will remain the same for the ensuing year: They are: President, Mrs. T. H. Smith; President-Elect, Mrs. Robert Gill; Vice-President, Mrs. W. A. Drury; Treasurer, Mrs. Charles Edel; Secretary, Mrs. A. H. Kimmel.

KNOX

More than 100 women heard Mrs. Margaret Trescott of Cleveland review Morton Thompson's book, *Not as a Stranger*, June 11 in the First Congregational Church, Mt. Vernon. Mrs. Trescott appeared under the auspices of the Auxiliary to the Knox County Medical Society. The committee in charge of the meeting included Mrs. James McLarnan, Mrs. Delbert Schmidt and Mrs. Thomas Bogardus, Jr.

Members of the Mercy Hospital Sewing Guild were guests of the hospital at a luncheon June 1st which concluded sessions for the summer. The afternoon was devoted to sewing. This guild is sponsored by the Medical Auxiliary with Mrs. Julius Shamansky as chairman and Mrs. Lynn Shutt, supervisor.

SANDUSKY

The season's final meeting of the Auxiliary of Sandusky County Medical Society was held at the home of Dr. and Mrs. Leon H. Moore, Buckland Ave. Members of the group entertained their husbands at a picnic supper.

A brief business session was held after the social hour. Mrs. A. P. Newman, retiring presi-

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1. Rev. Gastroenterology 20:744 (Oct.) 1953; abstract in J. A. M. A., 153:1580 (Dec. 26) 1953.

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dent, announced plans had been completed for sending two boys and two girls to summer camp. Assisting Mrs. Moore were Mrs. M. Riddell, Mrs. F. A. Visconti and Mrs. E. L. Koons.

TRUMBULL

The Trumbull County Medical Society and Auxiliary held a joint dinner meeting in May at Cafe 422. Dr. Edward E. Bauman introduced the speaker, Dr. Allen Schroeder, director of the Law Medical Center at Western Reserve Law School, who talked on "Law, Medicine and the Future."

It was announced that a treatment room has been donated to Trumbull Memorial Hospital and a doctor's call board to St. Joseph's Hospital by the Medical Auxiliary.

New members were introduced and the following new officers for the ensuing year were presented: President, Mrs. J. A. Ralston; president-elect, Mrs. E. E. Bauman, vice-president, Mrs. A. Hoodin; treasurer, Mrs. John Thomas; recording secretary, Mrs. Charles Anderson; and corresponding secretary, Mrs. Robert Willoughby.

Recommend Psychiatric Department At City Hospital, Cleveland

An article in the *Cleveland Plain Dealer* reports that the Cleveland Mental Health Association has recommended reestablishment of a department of psychiatry at City Hospital in Cleveland with a full professor of the Western Reserve University School of Medicine at its head.

It was pointed out that City Hospital has been without a department of psychiatry or any full-time psychiatrist since 1946, when the Hoover Pavillion, a 10-story building which housed the psychiatric department was turned over to the state to be operated as a receiving hospital.

A report of the joint committee of the Mental Health Association and the Cleveland Welfare Federation indicates that in 1950 more than 2,000 Clevelanders needed psychiatric service which were not available.

Drug Company Warned About Misleading Ad Claim

No barbiturate, or compound thereof, can be sold in Ohio except upon the prescription of a physician, the Whitehall Pharmacal Company, New York City, has been advised by the State Board of Pharmacy. The company had advertised that one of its preparations containing a barbiturate could be secured without prescription.

Following is the text of a letter from M. N. Ford, secretary, State Board of Pharmacy, to the company on this matter:

"Our attention has been drawn to your recent advertising of your preparation Primatene as well as to the sample which you have distributed to many drug stores in this state.

"We want to call your attention to the fact the Ohio law prohibits the distribution of any barbiturate, or compound thereof, except upon prescription from a licensed practitioner. Therefore, under the provisions of the Ohio law your proposal to distribute your preparation Primatene without prescription is illegal and specifically in violation of Sec. 3719.23 Ohio Revised Code, et seq., copy of which we are sending you under separate cover this date.

"I would also call your attention to the fact it is our opinion you are in violation of the fraudulent advertising law in Ohio by distributing such sample as above referred to and the literature accompanying same, insofar as same contains a misleading statement to the effect that it may be sold without prescription. In this connection your attention is called to Sec. 2911.41 et seq., Ohio Revised Code, which is likewise sent under separate cover.

"It is suggested that you take immediate steps to rectify any false impressions which may have been derived from your advertising prior to this date and that your advertising and marketing of Primatene conform to the provisions of the Ohio Revised Code as previously stated."



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Medical PR Institute To Be Held In Chicago, Sept. 1-2

The third Medical Public Relations Institute sponsored by the American Medical Association will be held at the Drake Hotel in Chicago September 1 and 2.

Designed primarily for public relations personnel and chairmen of state and county medical societies, this year's informal sessions are designed as an "idea exchange—a public relations seminar"—to stimulate the exchange of ideas in all areas of medical public relations.

As a guide to policy formation, one session will touch on emerging PR conflicts between the medical profession and psychologists, pharmacists, social workers and lawyers, and how to cope with them. Another discussion period—billed as a problem in communication—will endeavor to show how to get physicians to read society material sent to them. Institute registrants also will examine the importance of medical assistants—their organizations, activities and in-service training—in an attempt to build stronger PR in the physician's office.

Medical society-sponsored television programs again will be spotlighted. Other sessions of this "idea exchange" will be geared to—offering A. M. A. departments the benefit of constructive suggestions on improving services to local medical societies . . . hearing about a unique method worked out by a county society for selling physicians and the community on its PR program . . . receiving first-hand reports on several new PR projects.

Highlighting the Institute will be the premiere showing of A. M. A.'s newest TV film—"A Life to Save." Produced especially for use on local stations by state and county medical societies, this 27-minute film tells how a woman, duped by a quack, is saved from death by prompt action of her family doctor.

Dr. Ullery Named To Head Obstetrics And Gynecology at Ohio State

Dr. John C. Ullery, of Philadelphia, Pa., has been named professor and chairman of the Department of Obstetrics and Gynecology in the Ohio State University College of Medicine, effective October 1. He succeeds Dr. Allan C. Barnes, who resigned last year to accept a similar position at Western Reserve.

Dr. Ullery has been assistant professor of obstetrics and gynecology at Jefferson Medical School. He is also a faculty member of the University of Pennsylvania graduate school and is chief of the obstetric and gynecology service at Philadelphia General Hospital, Philadelphia Lying-In Hospital and Delaware County Hospital at Drexel Hill, Pa.

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Rx: Patient should remove self from all extraneous activity-situs, other than those of his own professional calling (from which the optimum profitable conversion of time into income can be realized) and whatever slight surplus of time remains used to the ultimate restoration from fatigue, worry and harassment.

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Need a model of a heart or an ear or a statistical chart showing average life expectancy today? As a service to medical societies producing local TV programs, A. M. A.'s Bureau of Health Education has prepared an extensive series of attractive visual aids available on a loan basis. Societies need only check with the Bureau for further information and pay just the return postage on all material borrowed.

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Dr. Gaillard Fuller Honored by Loudonville Community

Loudonville went all out on June 8 to pay tribute to Dr. Gaillard B. Fuller, who has served that community for 50 years. Dr. Fuller went to Rotary dinner and then to the high school auditorium where he discovered 300 residents of the community there to do him honor.

Among distinguished guests present were State Representative J. Frank McClure. Congratulations were received from Governor Frank J. Lausche, Lieutenant Governor John W. Brown, Congressman J. Henry McGregor, Dr. Edward J. McCormick, President of the American Medical Association, and many others.

Dr. H. T. Pease, Wadsworth, Councilor of the Eleventh District of the Ohio State Medical Association, presented Dr. Fuller with the 50-Year Pin of the Association. Mayor Edward L. Smith presented him with the "Key to Loudonville" and proclaimed October 6 "Doc. Fuller Day" at the Loudonville annual fair.

A feature of the program was a "This is Your Life" dramatization by the Rotary Club. The *Wooster Record* carried a feature story on the meeting which occupied the major part of four columns.

Dr. Fuller's father and grandfather practiced in Loudonville before him. Five other members of the family also were physicians in the community.

Physicians and their wives of Ashland joined with the Rotary Club and other groups in the celebration.

Recent Legal Opinions Given By the Attorney General

Recent opinions given by Attorney General C. William O'Neill concern compatibility of office of coroner and health commissioner, and use of funds received by board of health for license fees.

COMPATIBILITY OF OFFICES

The Syllabus of Opinion No. 3747 is as follows:

1. There is no incompatibility between the office of coroner and employment as health commissioner as authorized by Section 3709.11 of the Revised Code.

2. Whether a health commissioner employed by a board of health under a contract wherein the officer is to give his "full time" to work of such office, is violating such contract by serving as coroner, is a matter for the determination of the board of health.

3. Where a coroner, duly elected and serving in such office is employed by a board of health as health commissioner "on a full time basis," and is permitted by said board to continue, while serving as health commissioner, to perform his duties as coroner, he is entitled, in addition to

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GYNECOLOGY—Office & Operative Gynecology, two weeks, Sept. 20. Vaginal Approach to Pelvic Surgery, one week, Sept. 13.

OBSTETRICS—General & Surgical Obstetrics, two weeks, Oct. 4.

MEDICINE—Two Week Course Sept. 27. Electrocardiography & Heart Disease, two weeks, Oct. 11. Gastroenterology, two weeks, Oct. 25. Gastroscopy, one week, Sept. 13.

RADIOLOGY—Diagnostic Course, two weeks, Oct. 4. Clinical Uses of Radio Isotopes, two weeks, Oct. 4.

PEDIATRICS—Clinical Course, two weeks, by appointment. Congenital & Rheumatic Heart Disease in Infants & Children, one week, Oct. 11, and Oct. 18. Two weeks, Oct. 11.

UROLOGY—Two-Week Urology Course, Sept. 20. Ten-Day Practical Course in Cystoscopy every two weeks.

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his compensation as health commissioner, to receive his compensation as provided by law for his service as coroner.

FUNDS FROM LICENSE FEES

The Syllabus of Opinion No. 3793 is as follows:

1. Information relative to the funds received by a board of health from license fees for restaurants, pursuant to Section 3732.01 et seq., of the Revised Code, must be reported to the county budget commission under the provision of Section 5705.29, Revised Code.

2. The board of health of any health district is authorized to expend the funds realized from license fees levied pursuant to Sections 3732.01 to 3732.08, inclusive, of the Revised Code, for the purposes therein prescribed, and the county budget commission is without authority to limit or control the appropriation or expenditure of such funds.

Records Show Birth Rate Still on Increase

The national birth total in the first four months of 1954 topped the same period of 1953 by about 30,000, according to vital statistics estimates released by the Public Health Service.

But marriages this year have continued to fall, after sinking in 1953 to 9.7 marriages per thousand population, the lowest annual rate since 1933. Compared with the first four months of 1953, marriages in the same period this year dropped by 25,000. The marriage rate for the period fell by 7.2 per cent.

The level of births for the first third of 1954 is running at a slightly higher annual rate than for the first third of last year. Total registered and unregistered births in 1953, estimated at 3,971,000, broke all previous records. This gave a rate of 25.1 births per thousand population, one of the highest in many years.

Relatively few young people have been reaching marriageable age in recent years because of the low birth rates of the 1930's, the Service pointed out. Moreover, the wave of marriages beginning in 1946, when an all-time peak of 2,291,000 marriages occurred, sharply reduced the number of single young people in the population.

Much of the increase in births this year and last year can probably be attributed to a continuing rise in the number of third and fourth children. An increase in the number of first births is not expected, because of falling marriage rates since 1951.

During the past 10 years, a total of 3,600,000 veterans—one out of every five men and women who served in World War II—obtained V. A.-guaranteed and insured loans valued at $23.5 billion.

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Drownings Account for 6,500 Deaths Annually

Summer recreational activities renew the threat of drownings, which claim about 6,500 lives annually in the United States and are at their year's peak in July, statisticians of the Metropolitan Life Insurance Company warn.

Male victims outnumber females by six to one, and the highest death rate from drowning is recorded among boys 15-19 years of age. Swimming accounted for about half the fatalities among these youngsters and boat accidents for an additional one-fifth.

A large number of drownings occur each year among children at ages one to nine as a result of the youngsters falling into or wading in rivers, creeks, and other bodies of water. Among the very young children a considerable proportion of the fatalities occur around the home—some of them in ornamental garden pools, cesspools, septic tanks, wells, and cisterns.

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Through your doctor you can take advantage of the vast resources of medical science and recent advances in treatment of many conditions.

Perhaps, at the moment, you don't have a family physician. If not, start making inquiries *now* — don't wait for an emergency to force you into a frantic search for a doctor.

You may wish to consider several doctors before you pick the one who is "right" for you. Once you have made your selection, give him your complete confidence, as you would any other trusted member of your family circle. Remember, your doctor is the best "preventive medicine" your family can have.

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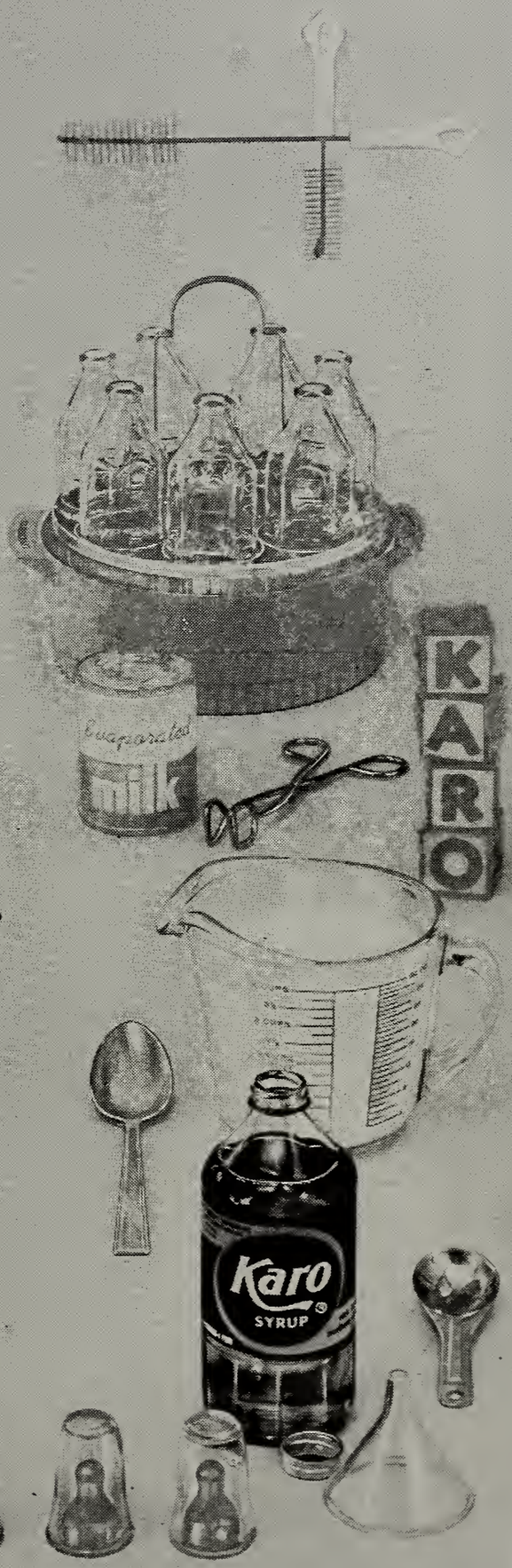
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Why We Became Doctors, edited by Noah D. Fabricant, M. D., ($3.75. *Grune and Stratton, Inc., 381 Fourth Ave., New York 16, N. Y.).* Men and women study medicine for many reasons. Some enter the practice as the result of the impact upon them of many factors. In some, the most important is a family tradition of a long line of physicians; in others there is a keen desire of their relatives to have a professional man in their social circle. For both of these, medicine offers the greatest satisfaction.

"In my generation," writes Jonathan Forman, in the recently-published book, **Why We Became Doctors**, "quite a few drifted into the profession because the obstacles which now beset professional education were not in existence. It's impossible, nowadays, to drift into medicine. Most all who do enter recognize that physicians enjoy prestige in the community, a standard of living that is above average, and a good income. There is no blame attached to the desire for any or all of these things in a country dedicated to free enterprise. If, however, the desire to serve mankind is not one of the compelling factors in making up the minds of youths to come into medicine, it is most unfortunate. One single, selfish man seeking only gain for himself can do a great disservice to his community if he attempts to practice medicine. Sometimes I wonder about this expenditure of time and money and about the family background of young people who can afford to spend some 12 or 15 years and $15,000 in cash. It may just be that more frequently than formerly, under these conditions the medical student may come from a home where sharp trading and 'markup,' rather than service to mankind, may be the dominant motive. On the other hand, the difficulties and obstacles in the way of a medical education today may act selectively and only those to whom it matters terribly will make the grade. Psychologically, of course, I would be afraid of a student whose only motive was to 'serve mankind.' This is a reflection on the kind of student and not upon the desirability of such a motive as one of the factors which has determined the student's course."

The publisher has secured the services of Dr. Noah D. Fabricant, an Associate Editor of the *Journal of the American Medical Association*, and author of several popular books on diseases of the throat and tonsils, to assemble a book of fifty statements by representative physicians on why they became doctors. He has gone into the field and selected writings from about 16 or 17 men who are dead, but who left behind in their autobiographies or in their writings clear statements of why they had embarked on medicine. The remaining two-thirds of the men quoted is divided pretty evenly between those who have a medical education but have taken up writing or other professions for their lifework—such as A. J. Cronin, and W. Somerset Maugham—and practicing physicians, most of them well-known specialists in a variety of fields.

Dr. Forman's autobiographical contribution emphasizes that a career in medicine need not be planned, but that the good things in life "come to us when our minds have been made ready to receive them. This is where the liberal education comes in, and where the vocational type of teaching fails. Our minds are conditioned through their application to the interesting things at hand. If our interests have been broad and our application intense, then our minds will more likely be sensitized to react to opportunity when it comes our way. What look like accidents become opportunities for those who happen to be ready for them."

Tissue Culture, by Edward Nevill Willmer, Sc. D., (2.25. Second Edition. *John Wiley & Sons, Inc., New York 16, N. Y.).* This book is recommended to anyone wishing to learn about or practice tissue culture. In the past this technique has been the object of much misrepresentation and false concepts. This volume, however, will prove a safe guide. It points out the limitations of the method as well as its advantages as a tool for investigation. One of the most valuable parts is the bibliography of 410 references.

Textbook of Virology, by A. W. Rhodes, and C. E. Van Rooyen, ($8.00 Second Edition. *Williams & Wilkins Co., Mt. Royal Ave., Baltimore 2, Md.).* A succinct account of the essential features of the virus and rickettsial diseases of man.

Manual of Clinical Mycology, by Norman F. Conant, David T. Smith, R. D. Baker, J. L. Callaway and D. S. Martin, ($6.50. Second Edition. *W. B. Saunders Co., Philadelphia 5, Pa.).* Since the introduction of penicillin and other potent antibiotics for the control of the acute bacterial diseases, fungus infections are more frequent and more important. This book brings the physician up to date on the subject.

Facial Deformities and Plastic Surgery; A Psychosocial Study, by Frances Cooke MacGregor, Theodora M. Abel, Albert Bryt, Edith Lauer, and Serena Weissmann, ($5.75. *Charles C. Thomas Co., Springfield, Ill.).* This book is the result of inter-disciplinary research conducted by specialists in cultural anthropology, clinical psychology, psychiatry and sociology. It is the first to deal with the multifaceted aspects of facial dis-

figurement in our culture. This is a contribution to the problem of handling these patients and helping them to adjust themselves properly.

The Anatomy and Surgery of Hernia, by L. M. Zimmerman, and B. J. Anson, ($10.00. *Williams & Wilkins Co., Baltimore 2, Md.)*. Nowhere in surgery is the relation between adequate technique and satisfactory end results more evident than in the management of a hernia. Here an anatomist and a surgeon of wide experience have joined to show us how to redirect our thinking in regard to the actual lesion present.

A Manual on Cardiac Resuscitation, by Robert M. Hosler, M. D., ($4.00. *Charles C. Thomas, Pub., Springfield, Ill.)*, presents information that should be known before and not after the crisis occurs. It is an amplification of principles set forth in the author's article in this *Journal* (48:228, 1952), on "Training in Cardiac Resuscitation."

Steps in Psychotherapy: A study of a Case of Sex-Fear Conflict, by John Dollard, Frank Auld, Jr., and Alice M. White, ($3.50. *The MacMillan Co., New York 11, N. Y.)*. From the Institute of Human Relations of Value with the emphasis on the patient's immediate problem. The treatment is a blend of a reinforcement learning theory and psychoanalysis, with Freud providing the power, and learning theory the precision.

Safer Smoking, by Clarence William Lieb, ($2.50. *Exposition Press, New York 10, N. Y.)*. A Banner book, which gives what every smoker should know about himself and his habits. The author does not tell you to stop smoking, but gives advice on how to avoid some of the effects of smoking which, according to him, may result in many manifestations of subnormal health, such as cancer of the lungs, Buerger's disease, etc. His philosophy has a tinge of ecology: "We must not forget that 'life is a balance incessantly menaced.' Destroy all the predatory animals in the district and you may have a rabbit pest. Spray a crop unscientifically and you kill the parasites and their enemies. Certainly the tobacco addiction of today has its advantages over the alcohol addiction during our prohibition era with its devastating effect upon the moral, physical and economic health of our country." Prohibition, he believes, will never solve our tobacco health problem, and therefore he attempts to concentrate the reader's attention on how to attain safer smoking, which, to your reviewer, is a much saner way to combat the $20,000,000.00 per year spent for advertising tobacco products. The 3000 youths who begin to smoke every day of the year in this country are greatly in need of the advice contained in this book.

1954 Current Therapy, edited by Howard F. Conn, M. D., ($11.00. *W. B. Saunders Co., Philadelphia 5, Pa.)*, gives approved methods of treatment for the practicing physician and is unique in that, as an annual volume, it gives the methods that some particular doctor uses in the treatment of a specific disease. Your reviewer presents his method of treating hay fever (nasal allergy; allergic rhinitis). This method of producing an annual series avoids the possibility of monotony and gives each annual volume a new attractiveness.

Hypertensive Disorders of Pregnancy, by Ernest W. Page, ($3.95. *Charles C. Thomas Co., Springfield, Ill.)*, is a monograph in the American Lectures in circulation. This group of related syndromes occurring in pregnant women is discussed under three headings. Chapter 1 presents the points of greatest interest to the practicing physician, Chapter 2, the factual material of special concern to the clinical physiologist, and Chapter 3 deals with speculations of primary interest to investigators of the cause of toxemia.

Lectures on The Thyroid, by James H. Means, ($3.00. *Harvard University Press, Cambridge, Mass.)*, collects in one volume lectures delivered in various places from June, 1949, to April, 1953. The titles are: The Integrative Action of the Endocrine System, The Thyroid Hormone, The Use of Hormone Drugs, and Radiation in the Management of Thyroid Disease, Clues to the Ideology of Graves' Disease, The Need for Iodine. Taken together these chapters epitomize the remarkable advances made in thyroid research in recent years. The whole life story of the thyroid as it is now emerging will be found in these pages.

The Cutaneous Manifestations of Systemic Diseases, by John Godwin Downing, ($4.25. *Charles C. Thomas Co., Springfield, Ill.)*, is one of the monographs in the American Lectures in Dermatology. There are thirteen chapters designed to give the physician who is not a specialist in skin diseases information which he badly needs. The skin is treated as the largest organ of the body, which rapidly reflects any pathology in the underlying structures.

Moments of Reflection, by Morris Weintrob, M. D., a memorial edition with a preface by Morris Fishbein, ($3.00. *Exposition Press, New York 10, N. Y.)*. These are the last poems by Dr. Weintrob, who died suddenly, less than a month before the book was published. His poems on man, on love, on America, and on the gallant new land of Israel, contain the essence of his beliefs, his wisdom, and his love for humanity.

The Billroth I Gastric Resection, with particular reference to surgery of peptic ulcer, by Horace G. Moore, Jr., and Henry M. Harkins, ($7.50. *Little, Brown & Co., Boston, Mass.)*. The purpose is to present a re-evaluation of the advantages and disadvantages of this operation in the light of recently acquired knowledge of physiology and surgical techniques. The conclusion is that sub-

total gastric resection is the best available operative treatment for peptic ulcer; that Billroth I anastomosis provides certain advantages over Billroth II procedure. Finally, there is good clinical and experimental evidence to indicate the superiority, physiologically speaking, of Billroth I over Billroth II procedure.

Symptoms of Visceral Disease, by Francis Marion Pottenger, M. D., ($7.50. 7th Edition. *C. V. Mosby Co., St. Louis 3, Mo.).* For the past thirty-five years, physicians have turned to this now-classical work in their search for an explanation of the normal and pathological reactions in man. The emphasis is upon man's reaction to his internal environment; through his descriptions of negative reactions the author has led us to a better understanding of disease.

Hope and Help in Parkinson's Disease, by John C. Button, Jr., ($4.95. *Vantage Press, Inc., New York 1, N. Y.),* comes with a recommendation of Dr. Martin Gumpert, saying that "Dr. Button's book fills a gap in medical literature. Parkinson's disease is one of the most misunderstood and disabling of diseases."

Doctor Pygmalion, the Autobiography of a Plastic Surgeon, by Maxwell Maltz, M. D., ($3.50. *Thomas Y. Crowell Co., New York 16, N. Y.).* As well as introducing the reader to the facts of modern and ancient plastic surgery, and describing step by step a variety of intricate operations, this autobiography, with its movement and color, tragedy and romance, comedy and heartbreak, is a fascinating account of people and their problems, and how one man, through his skill, has helped them solve them.

You and Your Health, by Edwin P. Jordan, M. D., ($3.95. *G. P. Putnam's Sons, New York, N. Y.).* Based upon the inquiries of readers of the author's syndicated column, the writer has presented what he believes the people want to know about their own and their family's ailments.

The Metabolism of the Tubercle Bacillus, by William F. Drea, and Anatole Andrejew. ($12.50. *Charles C. Thomas, Pub., Springfield, Ill.),* brings up to date the information secured since the publication of Wells' and Long's **Chemistry of Tuberculosis** (1932). In that time a great deal of information has accumulated. This new book discusses the nutrition and growth of a bacillus, depth cultures, respiratory exchanges, enzymes, and metabolic products.

Periodontology—Diagnosis and Treatment, by Frank E. Beube, D. D. S., ($15.00. *The Macmillan Co., New York 11, N. Y.),* is a critical text covering every phase of the subject. Because the preservation of the teeth depends to a large degree upon the maintenance of health in the tissues surrounding them, this text will serve not only the dentist, but will also be of great help to the physician who will take time to read it.

Clinical Orthoptics, by Mary E. Kramer, ($12.50. 2nd Edition. *The C. V. Mosby Co., St. Louis 3, Mo.),* is a complete revision of this text, dealing with our rapidly increasing knowledge of the physiology of binocular vision.

Scientific American Reader 1953, ($6.00. *Simon and Schuster, New York 20, N. Y.),* has been put together by the editors of the *Scientific American,* using contemporary articles from this magazine which most effectively throw light on the big problems which concern all modern scientists. Ten different fields are explored with four or five important articles. They are: Evolution in Space, Structure of the Earth, Structure of Matter, Atomic Energy, Origin of Life, Genetics, Virus, Animal Behavior, Origin of Man, The Brain and the Machine.

Cardano, The Gambling Scholar, by Oystein Ore, ($4.00. *Princeton University Press, Princeton, New Jersey),* with a translation from the Latin of Cardano's **Book on Games of Chance** by Sidney Henry Gould. Cardano, next to Vesalius, was the greatest physician of his day. His mathematical genius was applied to the development of simple rules of probability for his own benefit and for his gambling contemporaries. These were collected in a book, and embellished with essays on tricks of cheats and kibitzers, as well as on the physical rules of play. As a physician, Cardano's skills were sought by kings and emporers. He was perhaps the most widely read author of popular science of the 16th century, and the overtones of mysticism and the occult in his writings brought him the censure of the Inquisition. Since most physicians enjoy gambling (for small stakes) this book should have a wide appeal.

Twenty Years of Psychoanalysis, edited by Franz Alexander, M. D., and Helen Ross, ($3.75. *W. W. Norton & Co., Inc., New York 3, N. Y.).* A symposium in celebration of the twentieth anniversary of the Chicago Institute for Psychoanalysis. Reviews what has been the impact, in the last two decades, of psychoanalysis on medicine and the social sciences.

Thyroidal Response to Goitogens by Desmognathus Fuscus (Rafinesque) Using Radioactive Iodine as Indicator, by Jacob Fisher, ($0.50. *Catholic University, Washington, D. C.).* This study undertakes to determine whether (1) the thyroids of urodeles treated with potassium thiocyanate, thiourea, or sulfanilamide for varying lengths of time concentrate iodine as effectively as those of normal animals; (2) there are differences in the effectiveness of inhibition; (3) thyroid regression occurs during long-continued treatment; (4) there are significant differences between warm-blooded and cold-blooded forms with respect to the type of thyroidal response to such treatment.

The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 50 September, 1954 No. 9

JONATHAN FORMAN, M. D., *Editor*

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Hydrocortisone Ointments: Their Rational Use in Dermatology

ASHTON L. WELSH, M. D., and MITCHELL EDE, M. D.

HYDROCORTISONE exerts the most potent anti-inflammatory action of any known steroid at tissue levels. Mechanism of action is unexplained[1, 2, 3, 4] but when improvement occurs, it is usually evident within 24 to 48 hours, and obvious after one to two weeks. Pruritus disappears, oozing and edema are controlled, erythema fades, crusting and scaling lessen, and the skin begins a return to normal. Exacerbation may follow therapy withdrawal, and eruptions are then, reportedly, more distressing than originally.[5, 6]

There is no evidence of percutaneous absorption, although effects have been noted not only in treated areas but also where no hydrocortisone has been applied—this "distant action" being variously attributed to an inhibition zone not limited to the area of intradermal reaction,[7, 8] and to absorption phenomena.[6] No absolute control of accidental or intentional patient-use on such sites has been established. Neither sensitization nor systemic ill-effect from prolonged use has been found to be an attendant risk of therapy.[1-4]

The literature records both disappointing response-to-therapy with hydrocortisone acetate,[7, 9] and encouraging response-to-therapy with hydrocortisone acetate and hydrocortisone free alcohol.[1-4, 10, 11, 12, 13]

In view of reports that topically applied hydrocortisone exerts only temporary suppressive action, that except in self-limiting dermatoses, such as acute contact dermatitis, therapy is regularly followed by a "rebound" of symptoms more acute and treatment-resistant than originally, and, that refractoriness to treatment follows prolonged application, we undertook to develop some rational approach to a technique for use of hydrocortisone ointments. Our study presents a clinical evaluation of such technique based on the premise that hydrocortisone, an agent capable of suppressing inflammatory processes, cannot supplant, but rather should supplement conventional topical therapy.

From October, 1953, until May, 1954, we treated a series of 402 patients chosen from private practice. These patients presented, generally, chronic dermatoses found, in our experience, to be refractory to conventional topical therapy. The preparations which we used were: cortril® (brand of hydrocortisone) acetate topical ointment, and cortril® (brand of hydrocortisone) free alcohol topical ointment, 1.0 per cent and 2.5 per cent

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Submitted June 12, 1954.

concentrations (10 mg. and 25 mg. per gram, respectively).* The 2.5 per cent concentration was prescribed where acuity of an inflammatory process appeared to warrant: the 1.0 per cent concentration was prescribed routinely. Our experience confirms the observation that therapeutic effectiveness between the two concentrations is not striking.[5, 6]

Hydrocortisone ointments were prescribed for application 3 to 4 times daily by gently smoothing onto and into the skin of the affected areas. Each patient was observed in 72 hours (if possible) after initial prescription, and all patients were observed at weekly intervals. During our study, actinic therapy was administered, where indicated; internal therapy was employed, as indicated; topical antibiotic agents were used when required to control infection; topical anti-eczematous and other therapeutic agents supplemented hydrocortisone therapy immediately in chronic cases, and just as soon as recession of inflammatory processes warranted in acute cases—the hydrocortisone being gradually reduced in dosage-application, and withdrawn from use altogether. Hydrocortisone ointments were reintroduced into topical therapeutic regimens only when exacerbation or recurrence intervened—the amount being determined by the condition, and the reduction in dosage-application and the withdrawal being again accomplished as soon as possible.

The accompanying Table 1 summarizes response in selected dermatoses.

ichthyol,® liquor carbonis detergens, naftalan, oil of cade, crude coal tar, shale oil, or other anti-eczematous agents, than on these agents alone. Such conventional anti-eczematous agents had produced initial improvement, but had been ineffective to completely control the conditions for which they were prescribed. Upon combination with hydrocortisone, however, response was accelerated, earlier withdrawal of the steroid was permitted, and adequate therapeutic control was maintained—thus obviating any "rebound" after hydrocortisone therapy. Twenty-one patients, who could no longer tolerate one or more of the above-named agents, showed complete tolerance and marked favorable response following combination with hydrocortisone.

Patients who improved, initially, on hydrocortisone, but who did not continue to respond to the point of clearance, showed improvement and completely cleared on the combination therapy.

In long-standing atopic dermatitis, chronic contact dermatitis, localized neurodermatitis with lichenification and endogenous chronic infectious eczematoid dermatitis, we used hydrocortisone simultaneously with other anti-eczematous topical agents, and appropriate systemic measures. Therapy was completed with other agents alone, as the hydrocortisone was withdrawn following subsidence of acute inflammation. Hydrocortisone used alternately with, or concomitantly beneath such agents was found to accelerate both degree and rapidity of response over that obtained with

TABLE 1—RESPONSE TO HYDROCORTISONE OINTMENTS

No. of Cases	Diagnosis	Hydrocortisone Ointments			Percentage of Improvement							
		Acetate	Free Alcohol	Both Acetate and Free Alcohol	75%—100%	50%—75%	25%—50%	None	Reactions	Greater Improvement Hydrocortisone plus Other Agents	Hydrocortisone Increased Tolerance to Other Agents	Secondary Infections Controlled by Antibiotics
56	Atopic Dermatitis (including Infantile Eczema)	31	8	17	54	2	—	—	—	38	4	2
178	Chronic Infectious Eczematoid Dermatitis	86	35	57	148	17	6	7	2	109	14	5
78	Contact Dermatitis	48	21	9	73	5	—	—	—	48	2	1
16	Neurodermatitis, Localized	6	4	6	12	1	2	1	—	11	1	—
14	Pruritus Vulvae	11	2	1	12	—	1	1	—	3	—	—
15	Pruritus Ani	6	6	3	12	—	1	2	—	3	—	—
4	Seborrheic Dermatitis	3	—	1	3	—	—	1	—	—	—	—
7	Stasis Dermatitis	3	1	3	6	1	—	—	1	2	—	—
14	Lupus Erythematosus	8	6	—	1	5	3	5	—	—	—	—
6	Lichen Planus	5	1	—	—	3	1	2	—	—	—	—
7	Psoriasis	4	2	1	1	—	4	2	—	—	—	—
7	Other Dermatoses	5	—	2	—	2	1	4	—	—	—	1
402		216	86	100	322	36	19	25	3	214	21	9

COMMENT

Our results are in general agreement with results reported by others. It was our observation that in 214 patients improvement was more rapid following combination of hydrocortisone with hydrocortisone alone, or with conventional anti-eczematous agents alone.

Recurrent episodes of atopic dermatitis, contact dermatitis, localized neurodermatitis and endogenous infectious eczematoid dermatitis which became, eventually, refractory to hydrocortisone when used alone, occurred less frequently and did

*Materials for study were supplied by Pfizer Laboratories Division, Chas. Pfizer & Co., Inc., Brooklyn, New York.

not become refractory to therapy when hydrocortisone was combined with other anti-eczematous agents.

In acute contact dermatitis, including dermatitis venenata due either to ivy or oak, in the absence of further contact with the offending agent, and in transient, mild episodes of atopic dermatitis or infantile eczema, we found hydrocortisone to be adequate as the sole therapeutic approach.

In dermatitis venenata, due either to ivy or oak, response to hydrocortisone alone was disappointing, as compared to response of other types of contact dermatitis. When combined with other appropriate topical agents, hydrocortisone tended to speed response. Pruritus was controlled more adequately and more rapidly than with other agents, alone. Reduction of inflammation seemed to be accelerated.

In uncomplicated idiopathic pruritus vulvae and/or pruritus ani hydrocortisone alone controlled subjective symptoms in 82.7 per cent of our cases. In pruritus vulvae and/or pruritus ani with eczematization, lichenification, seborrheic or psoriatic complications, the combination of hydrocortisone and other anti-eczematous, anti-seborrheic and anti-psoriatic agents was necessary to accomplish adequate response. Hydrocortisone alone proved inadequate.

In uncomplicated stasis dermatitis, hydrocortisone alone was found to be effective. In stasis dermatitis complicated by eczematization due either to chemical, or infectious, allergic factors, hydrocortisone alone was inadequate. Combined with other agents, hydrocortisone enhanced response to those agents.

In uncomplicated psoriatic and seborrheic lesions, hydrocortisone alone proved of little benefit. Such lesions complicated by eczematization due to chemicals, used therapeutically or contacted accidentally, were controlled—with regard to the complicating eczematization.

In 64.2 per cent of patients with chronic discoid, disseminated discoid and subacute disseminated lupus erythematosus, lesions subsided more rapidly when topical hydrocortisone supplemented systemic therapeutic programs.

In lichen planus, topical hydrocortisone aided in the control of pruritus, but appeared to accomplish little else.

Infectious complications, which occurred in nine patients (2.23 per cent) were easily controlled with concomitant appropriate antibiotic therapy. In view of the duration of hydrocortisone therapy in this series (from 4 to 227 days), and in view of the low incidence of secondary infections, together with the sensitizing properties of antibiotics through prolonged use, we deemed it inadvisable to use topical hydrocortisone combined with an antibiotic as a regular therapeutic approach. We prefer to employ concomitant antibiotic therapy only when there is secondary infection of an impetiginous or follicular type. For patients with exogenous infectious eczematoid dermatitis, stasis dermatitis complicated by some local infectious eczematous factor, and in interdigital and intertriginous dermatoses where infectious factors are frequently present, initial topical therapy consisting of hydrocortisone combined with an antibiotic is, in our experience, reasonable.

For 68 of the 100 patients (68.0 per cent) where both the free alcohol and the acetate ointments were used, the free alcohol was observed to act more rapidly and effectively than the acetate in controlling both subjective and objective symptoms. This may, perhaps, be attributable to the fact that the free alcohol provides a higher molecular concentration of hydrocortisone. In the remaining 32 patients, the free alcohol and the acetate seemed to be equally effective.

No variation in response to actinic therapy was observed following topical use of hydrocortisone.

Reaction to topical use of hydrocortisone was observed in 3 patients. In each of these patients, the reaction was proved, by subsequent patch tests, to be due to the ointment base, and not to the hydrocortisone.

CONCLUSIONS

Hydrocortisone, alone, may produce dramatic, temporary results, but, combined with conventional preventive and therapeutic procedures, it can be a most valuable adjunctive measure for dermatological use. Alone, hydrocortisone is an adequate, effective therapeutic agent only in acute contact dermatitis, in mild, transient flares of atopic dermatitis or infantile eczema, in uncomplicated stasis dermatitis, and in some cases of idiopathic pruritus vulvae and/or pruritus ani.

In long-standing atopic dermatitis, chronic contact dermatitis and localized neurodermatitis with lichenification, endogenous chronic infectious eczematoid dermatitis, stasis dermatitis complicated by allergic chemical or bacterial factors, hydrocortisone is an inadequate therapeutic agent when used alone, but a valuable adjunct to therapy when combined with other appropriate anti-eczematous topical and systemic agents.

In a large group of unrelated dermatoses, themselves unresponsive to topical hydrocortisone, improvement occurred when hydrocortisone was used to control eczematous complications or irritative phenomena of an inflammatory nature occurring during the course of these diseases. The free alcohol ointment appeared to be more effective than the acetate ointment.

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Prevalence of Trichinosis A Major Health Problem

Available statistics on prevalence of trichinosis come mainly from autopsy surveys. From these statistics some 25,000,000 persons are believed to be infected with Trichinella. Most of these are symptomless, or the infections have been mild, and have not been diagnosed clinically. Only about 400 actual cases of trichinosis are reported yearly in the United States, but it is estimated that there are at least 16,000 clinical cases occurring each year. From autopsy statistics, trichinosis appears to be more prevalent in the United States than in any other country and many represent the major uncontrolled health problem for which adequate means of control are available.

McNaught and Anderson, in 1936 studying preparations of diaphragms obtained at autopsy in the San Francisco area, reported incidence of 24 per cent. A recent study in 1950, by Beard from San Francisco, also from autopsy specimens, revealed a drop in this incidence to 8 per cent. This fall in incidence may be directly related to control of feeding uncooked garbage to hogs in this area. A study from Rochester, New York, in 1936, again based upon autopsy specimens, revealed an incidence of 17.5 per cent. Wright, reviewing the incidence in 1938, estimated a nationwide incidence of 17 to 18 per cent. A recent study by the United States Public Health Service of 2,330 diaphragms, obtained from 670 federal hospitals, disclosed an incidence of 16.3 per cent.

Prevalence of trichinosis is related directly to the practice of feeding raw garbage to hogs. Throughout the central part of the United States, where hogs are corn fed, the incidence of trichinosis in swine is 0.6 per cent, but increases rapidly in areas on the eastern seaboard and western United States, where garbage feeding is very common, to an incidence of 11.5 per cent.—Louis D. Fey, M. D., and Moore A. Mills, M. D., Seattle: *Northwest Medicine*, 53:701, July, 1954.

KEEPING UP WITH MEDICINE

• VITAMINS have not been shown to have any general stimulating action on the growth of cells *in vitro*.

* * *

• OVERDOSAGE, or too long treatment, with estrogens causes congestion of the breasts, excessive endometrial proliferation, digestive troubles, and vertigo. Androgens cause masculinization, irritability, and weight increase.

* * *

• AGRANULOCYTOSIS has followed the use of methimazole as have toxic hepatitis and loss of taste.

* * *

• PROTEIN DEFICIENCY in youngsters' diet due to ignorance is probably the most common dietary deficiency.

* * *

• THE MOST FREQUENT of the definitely dermatologic lesions in the perianal skin are the mycotic infections, usually with an associated secondary infection.

* * *

• ACCUMULATING EVIDENCE continues to support the conclusion that vitamin B_{12} plays an important role in the metabolic pathways involved in the intraconversion of carbohydrates and fat.

* * *

• IN ACTUAL PRACTICE, the behavioral reactions and the metabolic reactions of the patient to his life situations are not separate and in pure form as they may be demonstrated in the laboratory. They occur together and potentiate each other thus establishing a vicious cycle.

* * *

• CALCIUM is transported in the serum partly as proteinate. Normally the serum calcium concentration is a closely guarded constant. It is only changes in the skeletal physiology that effects changes in the serum calcium level.

* * *

• SUCH NONSPECIFIC problems as failure to grow, poor eating, frequent regurgitation, and rapid respiration are among the more common initial disturbances that may lead to the detection of congenital heart disease.

* * *

• WHEN THE PREGNANCY is complicated by rubella during the first trimester, the child is likely to have a persistently patent ductus arteriosus.

* * *

• IN THE EVALUATION of a case of bronchial asthma, it takes all of the skill of an experienced physician to weigh properly the allergic factor, the infection factor, and the psychologic factor. When the case is not going right, it is always a great temptation to overweigh the psychologic influence.—J. F.

Preventive Psychiatry—A Practical Approach in Public Schools

JACK HERTZMAN, M. D.

THE psychiatrist who goes into a public school system must reorganize and reorient his thinking completely. Up to now the training of a psychiatrist, as of the general medical student, has emphasized the study of the individual. Though there has been some awareness of that individual functioning in a social milieu, nevertheless the pace of the study has been relatively leisurely. The child patient is brought to him when he has displayed behavior which someone considers disturbing. Although some time may be devoted to lectures and group discussions with the idea that these duties are in the field of prevention, the psychiatrist considers his primary job is with the individual presenting a problem.

When he moves into the public school set-up, he must think in terms of large masses of so-called normal children and their development. He must think in prophylactic terms—how to develop optimum mental health. At the same time, he must be aware of the fact that today psychiatry is the popular theme. Everybody—parent study groups, social agencies, educators, ministers are getting into the act. What is the psychiatrist's role in all this?

THE FUNCTION OF A SCHOOL MENTAL HYGIENE CLINIC

After 13 years in the public schools of Cincinnati, we see the place of the psychiatrist taking definite form. The individual child remains at the center of the picture and is always the core of the program. Our school clinic has been primarily a diagnostic one. This limitation, of course, is more easily possible in a community like Cincinnati where relatively good resources for therapy, psychiatric and case work, exist outside the school system. But even with this limitation, certain principles of selection must be exercised in the acceptance of cases for study. The cardinal one has been the teaching value of the case for the school staff.

No case is ever actually rejected *per se*. The school clinic is the liaison between the school staff and the community resources. By thus channelling all psychiatric referrals, mutual understanding and tolerance are fostered.

The diagnostic service limitation need not be a hard and fast rule. By the same principle of selection occasionally we have taken on treatment situations. Teachers and principals, especially in the first flush of their contacts with psychiatry, want to know the end results; and they should.

Presented at the annual meeting of the Ohio Psychiatric Association, Columbus, Ohio, April 12, 1954.

The Author

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Such knowledge helps to further understanding and cooperation.

The February 22, 1954, *New York Times* carried a report on a three year research project under the auspices of Columbia University's department of psychiatry. It involved about 10 per cent of the country's public school population. The returns indicated 10 per cent of the children were emotionally disturbed; the range of the disturbance, as reported by the schools, was from 60 to .06 per cent of the children. Dr. David Abrahamsen, director of research for the study, in commenting on professional personnel needs to meet such a situation said, "If . . . we suppose that a city has some mental hygiene resources for children and that there is developed a system of educational and vocational guidance, we may indicate that a school system should have, ideally, one psychiatrist for 8,000 children, one psychologist for every 2,000 children, and one psychiatric social worker for every 3,000 children."

REALISTIC APPROACH TO SCHOOL PROBLEMS

As Dr. Abrahamsen figures it, Cincinnati with its public school population of 65,000 children, should have 8 plus psychiatrists. It has one, part-time. What can a psychiatrist in such a position do to influence the mental hygiene awareness of the public school system? On the basis of these figures the situation might appear pretty hopeless. Nevertheless, we believe that a great deal can be accomplished. The practical necessities of the reality situation have forced us to develop other techniques which we have called "Public Health Psychiatry." The keynote is prevention through understanding. Our practical approach has four principal features:

1. The public school psychiatrist must be accepted by the administration as a professional consultant on policy affecting the mental health of children. This is easier said than done. Quoting Dr. Abrahamsen again, ". . . although most

of the school officials . . . expressed some interest in the research . . . some showed a remarkable lack of understanding of mental hygiene concepts." The first step here is to win an acceptance as an individual—warm, understanding, and sympathetic; without the magical "horns" and mystic powers often attributed to psychiatrists. We came in through the back door, as it were, through the interest of the medical school rather than the public school people. Hence, we were someone imposed upon them, you might say, from the outside.

This first acceptance as an individual usually brings personal and then personnel problems from administrators and supervisors. The psychiatrist must recognize that a school system is a hierarchy with the community setting the pace. If he is fully aware of the fact that a good leader does not get so far ahead of his group that he loses contact with it, he can do much to interpret group feelings and reactions to the school administration and to members of the community.

2. The psychiatrist in the school system must be aware of the physical and mental health of the entire staff. We say "entire" advisedly, for sometimes the influence of a staff upon the well-being of a child can work in diverse ways. There is the seven year old girl who becomes an eating problem because the overly meticulous janitor in her school created such a fuss about the normal mess children make during a lunch period.

THE EMOTIONAL SIGNIFICANCE OF A PHYSICAL EXAMINATION OF A TEACHER

We, as professional people, accept without question the desirability of periodic physical examinations for all school personnel. Yet it can be recalled rather ruefully the tremendous furor that was engendered when such a program was first proposed in Cincinnati. The anxieties which were stirred by the plan had to be handled with patient understanding. To many, particularly older teachers, it represented a real threat. A great deal of time and effort were devoted to explanations of the program, to reassurances, and to giving teachers the opportunity to vent their feelings.

The physical examination program has been in operation now for seven years (started October 1, 1947). Physicians do the examinations, referring to us as psychiatrist-medical consultant only those situations where they have some question. Personnel may elect to be examined by the Board of Education physicians or by their own private doctor. In the beginning 67.5 per cent chose the Board of Education doctors. Today 76.2 per cent elect them. Many individual teachers have commented on the peace of mind they find in knowing that there are such examinations and subsequent reassurances.

But our program also included the non-professional staff. Explanation to this group at the outset had been minimal. As more and more people were examined and as there were increasing physical findings among this group which is a lower income one, we became aware of growing tension and anxiety. We have had group meetings to answer questions and to reassure them. It has been necessary to work with the examining physicians, too, so that they may be aware of the individual, the nature of his duties, and how much interpretation of physical findings can be given directly to him. One of the areas in which the medical schools do a poor job is right here.

Periodic mental examinations of teachers in service might sound ideal, but we believe such a program would represent an insurmountable threat, nor do we feel that it is really necessary. The school psychiatrist has many ways of becoming aware of the mental health status of the teachers. The periodic physical examination properly carried through and supervised is an important one. Far more important is the teachers' awareness of someone on the school staff to whom they may turn with their problems, personal and professional.

Often a little understanding of dynamics may help to clarify a situation and thereby eliminate what seems to be a serious mental health threat. A principal who had just taken over a school approached us about a first grade teacher. He felt that she had no control over her classes, was uncoöperative and unreasonable. Prior to this complaint the teacher had functioned well under another principal for many years. We learned that she was in her early 50's, in the menopause, unmarried, and that she had lost her father after a long and trying illness just prior to the opening of school.

Since a direct approach to either one seemed questionable, we decided to utilize the opportunity of a conference at the school about one of her so-called problem youngsters. The principal as well as the psychiatrist and psychiatric social worker were present. Her apprehensiveness at the beginning was most marked. As she realized that we were interested in her story, she began to relax and to discuss her classroom problems fully. The demonstration was good for the principal, who later advised that she was a "changed" woman. Actually, she was her old self again but he had changed more than she, i. e., there was an acceptance of her by him. Since this incident the teacher twice has participated in mental hygiene workshops led by us. She has been a good, contributing member of the group.

CRITERIA FOR NEW TEACHER SELECTION MUST BE DEFINED

In the selection of new teacher candidates, mental health evaluations should be standard operating procedure. Our chief task here is to ascertain what qualities we are seeking. What makes a good teacher? This is a good research problem. Over

the country people are concerned with this matter, but thus far no one has come up with a completely acceptable set of answers. Sometimes the psychiatric accepted norms for good personality adjustment do not seem to fit the picture quite as they should. The chief or outstanding mental qualification should be the ability of the individual to effect warm relationships, particularly with children, without projection of too many of his own problems on them.

Several years ago we were annoyed by an elderly teacher who seemed to sleep through an evening class on the dynamics of child behavior. When her name came before us a short time later for approval for appointment to a permanent position, we were tempted to say no, but gave approval when we learned that she had worked faithfully as a substitute teacher for 17 years. Recently she came to us about a personal problem. We found her a warm, friendly individual capable of effecting good personal relations with children. Incidentally, in the course of the discussion we learned that while taking our course at night this teacher had been caring for an ill husband and for the two young sons of a niece; that she was getting up at a very early hour in the morning to take care of all her responsibilities and be at her school on the other side of the city promptly.

TEACHERS' ATTITUDES ARE MOST IMPORTANT

3. We mention this situation preliminary to bringing up the third function—the school psychiatrist's concern with teachers' attitudes and relationships and how he may affect these. Formal lectures and courses are a part of the picture. However, there are other aspects which seem far more productive. Our experiences with the informal type of workshop approach lead us to feel that here is an approach which blends in well with the mental hygiene understanding and thinking. The group cohesiveness which can develop in two or three morning sessions is quite amazing. This can be used to discuss the individual child at the same time discussing dynamics of group forces with which the teacher deals constantly. The chief value of such experiences is not the formal knowledge acquired so much as the reassurance gained from the sharing of experiences with others who have similar problems. There is the growing tolerance and acceptance of both the child and teacher as individuals and their positions in the constantly changing group.

Conferences about individual children are a most valuable tool in understanding and influencing teachers' attitudes. There are two types of conferences, the one concerning the child who has been studied in the school mental hygiene clinic and the consultative conference about a youngster who may never be seen directly but whose adjustment can be aided by counselling with those directly involved with him. By this latter means the benefits of mental hygiene thinking are extended to many more children than could possibly be studied individually.

In the beginning of our public school experiences, teachers and others came to us at the central office for such conferences. This, for very practical reasons, curtailed the number of school personnel who could be reached by the conference method. We began to develop a policy of going into the schools whenever feasible for such meetings. We have found the extra drain on the time of the mental hygiene staff for traveling around well worth the results when we go into the school.

Because we have been fortunate in Cincinnati in having as director of personnel a man with excellent case work background and understanding and acceptance of mental hygiene concepts, we have been able to work out another method of procedure in influencing attitudes. This has been the selection and placement of key people in schools where we wished to develop understanding of mental health. Through the placement of just one skilled person it has been possible to improve the tone of a whole school.

GROUP MEETINGS WITH SAME TEACHERS ARE MOST PRODUCTIVE METHOD OF INFLUENCING ATTITUDES

Group meetings with the same teachers over a period of time have been just about the most productive method of influencing attitudes which we have used. In Cincinnati we more or less stumbled on to this method. In our program of mental hygiene curriculum we had to devise ways of supervising teachers who were new to that sort of material and who had many qualms about handling such material in the classroom. One phase of this program consists of human relations classes where the teacher is the leader of a group discussion about personal problems, and it was this activity which gave many teachers pause.

Meeting together at regular intervals to talk out our common problems became a real group therapy experience. Teachers became increasingly aware of themselves in the classroom situation and of the fact that relationship is a two-way street. Our problem here has been the fact that one-part time psychiatrist and one psychiatric social worker can meet with only a limited number of groups. This current year we have initiated the project of training teacher leaders for such teacher discussion groups. We hope in the near future to issue a report on our experiences in this area.

MENTAL HYGIENE CURRICULUM IS BIG AREA OF ACTIVITY

4. We indicated that our groups began in our mental hygiene curriculum program. This matter of curriculum is one of the biggest areas of influence and activity for the school psychiatrist. We have indicated in a previous paper[1] that edu-

cators are increasingly interested in the role of mental hygiene in the school curriculum. Actually, mental hygiene has played a role here for a long time. It is for the psychiatric personnel to see that the mental hygiene of the classroom is sound and that the educator is made fully aware of all the implications. We meet constantly with groups of teachers who are revising curriculum material to be sure that sound mental health principles are followed, that teachers understand their material in the light of the total child, and hence the significance of the classroom behavior.

THE CHILD AS A TOTAL BEING MUST BE CONSIDERED

The basic guiding principle in developing a mental hygiene curriculum is that the child is a total being functioning in many areas which are interrelated and interdependent and inseparable. We can recall a class of youngsters in a downtown tenement area school being taught the principles of modern health. The youngsters were going to school in a building over 100 years old and lacking in some of the most elementary hygiene facilities. They came from homes where frequently there were no hot water facilities, where toilets were shared with several other families, and basic necessities were lacking. When a teacher realized that he could not teach children who often did not even own a tooth brush to use one daily, he began to take a realistic view of these youngsters and their environment. He realized that he could not teach them from a prepared outline, that he had to consider the daily problems they faced, what they could do about their situation, and what had to be accepted. Then his approach was to a total child and was far more productive because it was far more realistic and far more tolerant.

The use of mental hygiene principles in the classroom begins with kindergarten. In one of our teacher discussion groups we have had teachers from the kindergarten who have contributed important human relations material to the group from their classroom experiences. In the lower grades the teacher must be aware of the opportune moment and the material as it arises from the classroom situation. The higher the grade, the more easily can the child verbalize about his feelings and his needs. In an earlier paper we described at length how in Cincinnati a mental hygiene curriculum has evolved out of the initial incentive of a war-born need. Today classes in human relations for credit are given in our high schools. Orientation courses and home room guidance programs are further opportunities for students to discuss their problems, share their experiences, and learn to relate themselves to the group.

In such a curriculum program the school psychiatrist has three important jobs: first, he must be aware of the materials and their authenticity; second, he must take a major role in the selection of teachers for such courses and in their supervision; and third, he must be sure that precautions are taken to make sure that the youngster in need of more personalized help is directed to the proper sources.

We stated at the outset that psychiatry today is riding the crest of popular interest. We believe that the school psychiatrist can do a great deal to channel this interest. What we have outlined does not represent an ideal program, but in the light of available financial and personnel resources, we believe that it does represent a realistic, practical approach.

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COMMENTS

On the Foregoing Paper Read by Dr. Jack Hertzman

By JOHN H. HERRICK, Columbus, Ohio
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PSYCHIATRIC service is an essential aspect of any complete school program. It is, however, found in relatively few places. While the future may look promising, any rapid approach to complete psychiatric service is hardly to be expected. In this connection, one may gain perspective by recalling that many older, and presumably well established, school services are still pretty meager in many communities and almost completely lacking in others. This is true of such diverse fields as health service, school libraries, and supervision of instruction.

To me the Cincinnati story as related by Dr. Hertzman is rich with suggestions for promoting more psychiatric services in schools. Three aspects of these suggestions stand out in my mind. First, he counsels patience in gaining acceptance of this new service, or, conversely, he seems to say that one cannot force a school staff or community to accept a new service until they understand it and have confidence in its potency as an aid in achieving the school's goals. Secondly, he proposes starting psychiatric services on the commonly accepted public health basis and

thus reduces the risk of wrecking the new enterprise on the rocks of controversy that would likely be encountered if individual treatment were more prominent in the scheme. Finally, and most significant of all, he placed his major hope on developing in teachers and other staff members a new outlook—new attitudes and understanding—with respect to mental hygiene.

The wise educational leader has long since learned that improvement of instruction starts in the minds and hearts of teachers, rather than in profound discussions or pronouncements by educational administrators and supervisors. In like manner, Dr. Hertzman recognizes that the emotional climate of the classroom, and in fact the mental hygiene of the staff itself, will be most effectively improved by approaches which build staff understanding and acceptance of mental hygiene principles. Approaches which would in any way cause staff apprehension, resentment, or emotional blocks to understanding are avoided.

As an educator, and not a psychiatrist, I see these aspects of the Cincinnati program as significant ways of gaining staff acceptance and understanding:

1. The "cardinal principle" in the selection of cases is the "teaching value of the case for the school staff."

2. The psychiatrist and school staff members join hands in studying problems of individual children and in seeking to improve mental hygiene in the classrooms. Solutions are sought coöperatively, not handed down ready made by the psychiatrist.

3. The educative process is carried on in ways which teachers have found effective in other aspects of their work. These include individual conferences, informal group meetings, and workshops. Formal lectures and readings are not used to any great extent.

4. The assistance of the psychiatrist is made readily accessible to staff members in the schools where they work; there is no need for them to go to a downtown board of education office for conferences and meetings.

5. Teachers are employed to assist one another in gaining insight into mental hygiene problems. This is done by judicious placement of enlightened teachers where leaven is needed, and by the training of teachers to serve as leaders of teacher discussion groups.

Antibiotic Anaphylaxis

Anaphylactic reactions following the injection of penicillin or other antibiotics have increased greatly during the past several years. These untoward reactions to penicillin were infrequent during the first nine years of penicillin therapy and there can be no doubt that hypersensitivity to these drugs is developing in many people.—Jason E. Farber, M. D., et al., Oakland: *California Medicine*, 81:9, July, 1954.

Psychological Essentials Of General Practice

In the process of helping the patient two special problems must be considered: advice, and information. Advising the person about specific ways of solving life's problems is seldom useful to him. Simply, if he were capable of accepting the advice, he probably would already have solved the problem in the logical way previously. If you give it, he may actually accept your advice and carry it out in a way to prove you wrong, saying: "I did it the way you told me, and look, what are **you** going to do now?" Obviously the patient is more dependent on you and has not acquired any new skills in handling his problem maturely.

On the other hand, information may be quite valuable. For example, factual information to an adolescent about masturbation may reduce many of his guilt feelings and allow improvement in general functioning by the attendant relief of anxiety.

One should always search for the reasons behind the request for information. If these reasons appear irrational or neurotic they should be explored with the patient.

After improvement has been obtained, the problem of how to terminate the helping relationship must be faced. We frequently underestimate how much the relationship has meant to the patient and forget that terminating it may be a great blow to him. Thus, when our goal of relief of symptoms for which treatment was started seems to be reached, it is well to bring up termination, preferably when the patient himself has shown he is also thinking about it. Usually he will bring this up indirectly by mentioning how much better he is, or by seeming to have little in the way of problems to talk about. It is well then to make some simple remark like: "You're wondering how much longer we will need to continue." He may agree and then between you a few final interviews can be arranged.

If the patient denies the suggestion, and you now believe he is ready for termination, it will be necessary to talk with him about his fears of not seeing you any more—essentially his fears of loss of your support.

In any event several terminating interviews should be set in order to give you a chance to work with his fears about "going it" on his own.

Never forget that the relationship has meant much to the patient and that terminating will have some element of abandonment to him. This feeling of rejection should be watched for and talked about as a normal reaction to terminating any close relationship. — Franklin G. Ebaugh, M. D., Denver, Colo.: *South Dakota J. Med. & Pharm.*, 7:98, April, 1954.

Treatment of Fracture of the Tibia by Rigid Fixation And Early Weight Bearing

ROY C. ROUNDS, M. D.

THE importance of early, accurate reduction and effective immobilization as local factors favorably influencing the healing of fractures has been recognized for many years. Only recently, however, has the beneficial effect of the dynamic compression force of muscles surrounding the fracture,[1, 2, 3] and of early restoration of function of the disabled part been fully appreciated. The slotted plate[4] originated from the desire to take advantage of muscle compression. Ingenious functional splints for the injured hand, the intramedullary nail and pin, and the half-pin splints of Stader and Anderson had their inception in the desire to restore function early after injury.

The enthusiasm for early restoration of function has been directed mainly, however, toward the early mobilization of joints and early muscle activity. Less emphasis has been placed upon restoring at an early period the main function of weight bearing long bones, namely that of bearing the weight of the body. Enthusiasm for permitting the fractured tibia and femur to

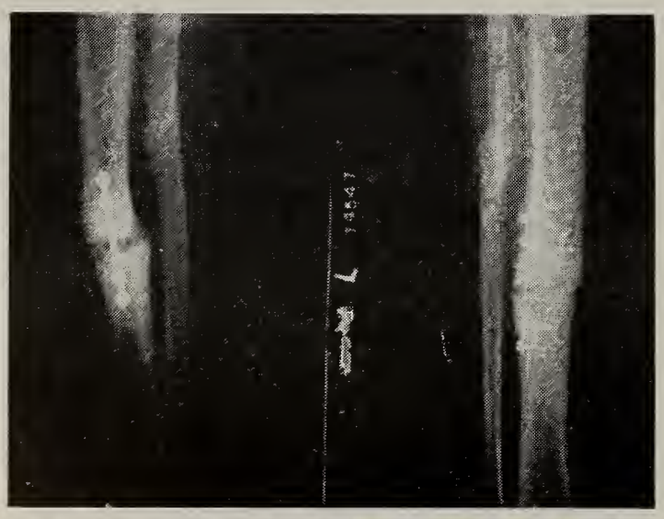


Fig. 1. Non-union resulting from a plate too small to be effective, fixed with screws that grasp only one cortex and holding the fragments in distraction.

bear weight early has been tempered as a result of individual experiences with refracture or displacement of fragments in spite of the protective qualities of internal fixation devices.

The legal entanglements that may result from these accidents has induced an attitude of conservatism. As a result femurs and tibias are pinned or nailed or plated, followed by encasement of the extremity in plaster, and weight bearing is avoided until confidence is restored by the appearance of callus in the roentgenogram.

There are instances where a severely comminuted fracture, marked soft tissue injury or an aged or uncoöperative patient precludes early weight bearing, but there is another group of patients where there is little justification for the use of internal fixation if external immobilization and nonweight-bearing for long periods follows surgery. The healthy, intelligent, muscularly coördinated adult whose bravado can be curbed following the use of such massive metallic supports as plates and intramedullary nails needs no additional external support and is quite capable of walking after the immediate reaction of surgery has subsided with a minimum of danger of refracture or displacement of fragments. The danger is probably no greater than that resulting from the activity of hobbling around on crutches with a suspended extremity encased in a cumbersome plaster cast.

The round-holed plate has been unjustly accused of contributing directly to a high incidence of nonunions when the fault lies in the unskilled application of the plate and not to its design, or to the use of a plate too small to do the job intended (Fig. 1). Its use does eliminate the beneficial effect of muscle compression but the advantage obtained by a stability of reduction not obtained by other methods, outweighs this fault by permitting unencumbered weight bearing at the earliest possible moment.

It is the purpose of this paper to present a group of 51 selected cases of fracture of the tibial diaphysis treated by open reduction using a round holed plate for fixation, where weight bearing was begun between the seventh and tenth postoperative day without the protection of casts or braces. These cases were treated during a six year period in the military services at William Beaumont Army Hospital and Wright Patterson Air Force Base Hospital.

OPERATIVE TECHNIQUE

Only the important aspects of the operative procedure will be described. The fracture is ap-

Submitted January 22, 1954.

The Author

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proached through a lateral curved incision to avoid a scar directly over the tibia and over the plate which is applied to the medial surface of the bone. The medial surface of the tibia and the fracture site is exposed by retracting skin and subcutaneous tissue medially. Application of the plate to the medial surface simplifies the procedure, permits more accurate application of the plate than is possible when the lateral surface is chosen, and, in this series, has not caused the patient discomfort due to its relatively exposed position.

The mechanical and technical aspects of plate fixation of bones has been described in detail by Peterson[5] who emphasizes the importance of correct choice of plate and screw, the correct relationship of drill hole diameter to screw diameter and other seemingly minor yet important details of plate application. Accurate hairline reduction of the fracture is essential.

A six hole size B Collison or Army type plate was used in each case of this series. It is fixed first to the proximal fragment using a center guide to place the drill holes and screws of similar metal and of sufficient length to engage the full thickness of the opposite cortex. The use of the electric drill to make the screw holes[6] encourages burning with resultant necrosis of surrounding bone and early loosening of the screw. To reduce this danger all holes are hand drilled using fresh, sharp drill points.

When the plate is firmly fixed to the proximal fragment an assistant compresses the fragments axially and the lower three screws are applied. It is at this stage that centering of the screw is most important because any pressure of the screw shaft against the proximal margin of the plate hole will obviously distract the fragments. Off-centering the screw hole slightly toward the distal margin of the plate hole will cause compression of the fragments but frequently prevents complete countersinking of the screw head in the plate.

Because comminuted fractures with their large fracture surfaces seem to produce radiographic evidence of callus earlier and in greater abundance than non-comminuted types it was the practice in this series to increase raw fracture surface and to produce a rather primitive type of autogenous graft by drilling as many 1/8 inch drill holes as possible along the exposed fracture line. The drill shavings are then repacked into and along the artificially serrated fracture line. Following closure of the wound a simple gauze dressing is applied and the leg wrapped firmly with a non-rubber-containing elastic bandage over a double layer of sheet-wadding from the base of the toes to the upper thigh.

POSTOPERATIVE CARE

The leg is elevated on two or three pillows for about 72 hours postoperatively and then the patient is encouraged to sit with the leg flexed over the side of the bed for short intervals with elevation continued while he is resting or sleeping. Between the seventh and tenth postoperative day he begins short periods of walking using crutches for support. The foot of the affected extremity is placed on the floor and as much weight as he is able to bear without discomfort is permitted. Within a week the average patient is bearing, still with the aid of crutches, as much weight on the fractured leg as on the normal one. Crutch support is continued for about a month after surgery followed by a cane for an additional three or four weeks. A majority of the patients have discarded the cane two months postoperatively and are performing light duties.

RESULTS

To emphasize that success of treatment is also dependent upon proper selection of cases table 1 lists all the types of tibial fracture admitted during the six year period. Only 51, or 27.4 per cent, of a total of 186 cases fulfilled the requirements of age, temperament, muscular coördination and type of fracture permitting ambulation and weight bearing 7 to 10 days after the operation. Many of the other cases, however, were weight bearing in casts or splints within a month after fracture.

TABLE 1—BREAKDOWN OF ALL TYPES OF TIBIAL SHAFT FRACTURE TREATED DURING A SIX YEAR PERIOD IN MILITARY HOSPITALS

		Number of Cases
I	Closed, undisplaced or incomplete fractures immobilized in casts only	32
II	Open fractures. Debrided and reduced without internal splinting	27
III	Open fractures. Debrided, reduced and internal fixation done after primary wound healing (2 infections after plate was applied)	12
IV	Severely comminuted fractures treated by closed or open methods	14
V	Bilateral fractures of the tibia and cases with associated head or visceral injuries or other associated fractures	29
VI	Tibial fractures of all types treated elsewhere and received in transfer at a late period of healing (This group includes 2 cases with non-union where the slotted plate was used)	21
VII	Closed fractures (transverse, oblique, spiral, one butterfly fragment) treated by rigid fixation with a round hole plate and weight bearing started early	51 (27.4%)
	Total	186

Representative radiographic findings at the time of injury and at about the date of discharge to duty are illustrated in figures 2, 3, 4 and 5. Callus usually was visible in the roentgenogram by the fourth postoperative week and was more prominent along the cortex opposite the plate. This suggests that a slight hinge motion occurs due to springing of the plate on alternate pressure and release of pressure during walking. There were no instances of refracture, grossly

bent plates or loosened screws in this series in spite of the fact that most of the patients were healthy, normally active individuals who, once confidence was restored in the weight bearing ability of the fractured leg, were inclined to ignore the activity limitations prescribed. One patient was discovered playing ping pong in the Red Cross building three weeks after surgery.

Table 2 shows the number of weeks from the time of injury to return to light and full duty. The spread between 12 and 24 weeks is due mainly to occupation and not to differences in healing time. A clerk obviously can be restored to duty sooner than an airplane crew chief, or an infantryman. The average interval of 16.3 weeks between injury and duty, however, is not completely accurate because of the administrative delay encountered between the time the patient was considered medically fit for duty and the time he actually was discharged from the hospital. This administrative lag averaged about 18 per cent of total hospitalization.

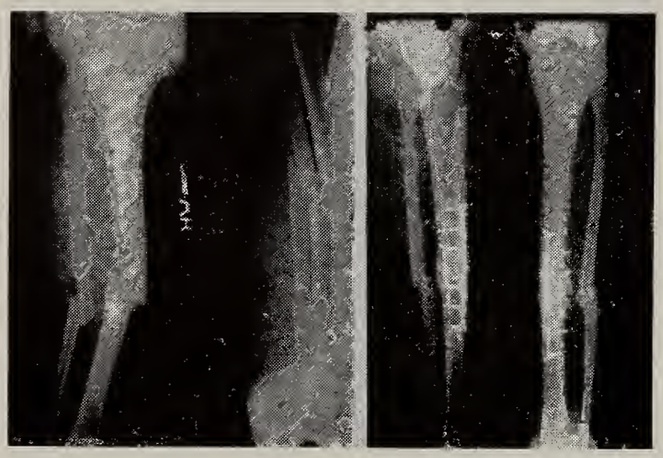


Fig. 2.—a. (Left) Oblique closed fracture of tibia and fibula resulting from a fall from a horse. Soldier, age 21. —b. (Right) Roentgenographic appearance upon discharge to duty 16 weeks later.

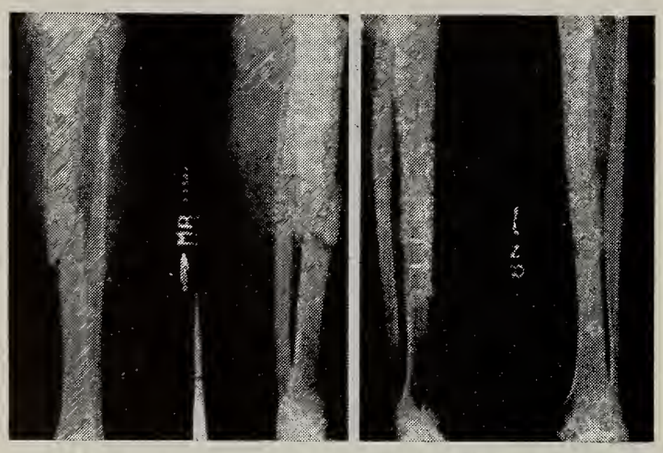


Fig. 3.—a. (Left) Closed fracture of tibia with single butterfly fragment. Soldier, 31 years of age, struck by an auto. —b. (Right) Roentgenographic appearance on discharge to duty 15 weeks after injury.



Fig. 4.—a. (Left) Closed spiral fracture of tibia and fibula incurred by a colored soldier, age 24, during a boxing match. —b. (Right) Roentgenographic appearance 13 weeks after injury upon return to duty. (One of 4 cases treated with transfixion screws only.)

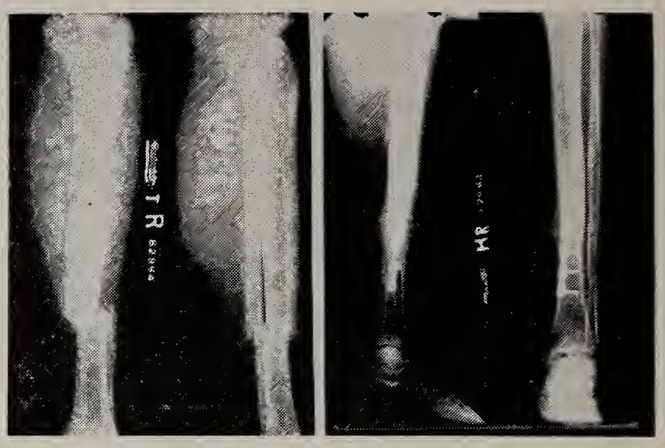


Fig. 5.—a. (Left) Transverse, closed fracture of tibia and fibula resulting from a motorcycle accident. Soldier, age 22. —b. (Right) Roentgenographic appearance 17 weeks after injury upon discharge to duty.

TABLE 2—INTERVAL IN WEEKS BETWEEN INJURY AND RETURN TO DUTY

Weeks	Number of Cases	
	Light Duty	Full Duty
10	1	
11	3	
12	5	2
13	7	2
14	13	4
15	12	10
16	6	9
17	2	10
18	0	6
19	1	3
20	0	1
21	0	2
22	1	1
23		1
24		
Average	13.9 weeks	16.3 weeks

Healing of the fracture was considered complete when there was no discomfort upon forceful torsion or bending directed at the fracture site, when local tenderness to pressure about the fracture site had disappeared and when the patient was able to jump up and down on the affected extremity without discomfort. Roentgenographic evidence of callus bridging the fracture after these tests were done completed the impression of satisfactory union although in a majority of the cases a fracture line was still discernible. Fracture lines may persist a year or more after solid union has occurred.

There were no infections in this series but in three cases a superficial necrosis of a small area of the skin along the wound margin developed

due to a too snugly applied pressure dressing. Two patients developed a hematoma that produced dark bloody oozing from the incision for three or four weeks before healing occurred.

Without a comparative control series it would be inaccurate to conclude that early weight bearing had any direct beneficial influence upon healing of the fracture. The absence of ankle and knee pain and stiffness is impressive, however. Physical therapy need be directed only to active restoration of muscle power and such passive treatments as whirlpool baths, heat and massage are unnecessary. Atrophy of calf and thigh is reduced to a minimum and the patient's general appearance and sense of well-being is rapidly restored. Demineralization of the bony structures distal to the fracture due to circulatory stasis[7] is practically eliminated.

SUMMARY

A series of 51 closed fractures of the tibial shaft is presented in which the fracture was treated by open reduction, rigid plate fixation followed by graduated weight bearing by the tenth postoperative day without cast or brace support.

Successful results are dependent upon careful selection of patients and type of fracture, and upon meticulous attention to the mechanical principles of plate application. Rigid fixation, eliminating the beneficial effect on bone healing of the compression forces of muscles surrounding the fracture, does not inhibit healing if these criteria are observed and weight bearing is begun early.

The patients in this series were all healthy, young adult, military personnel with closed fractures of transverse, oblique, spiral or single butterfly type involving the middle one third of the diaphysis. All fractures healed sufficiently to permit return to regular military duty after an average interval of 16.3 weeks following reduction. There were no instances of refracture, bending or breaking of plates or other mechanical failures.

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Milkman's Syndrome. In 1930 and again in 1934, Milkman described a new syndrome. The characteristic signs were fracture-like rarefaction zones in the bones, visible in roentgenograms. They are not true fractures, according to Milkman, but a kind of atrophy of the bones.

Ulcers Need Not Be Unusual Hazard to Longevity, Insurance Survey Shows

Ulcers, caught in time, do not necessarily represent any unusual hazard to longevity. This is indicated in a study of 15 years' mortality experience among 725,000 life insurance policyholders with some known health impairment, published by the Society of Actuaries.

Of about 45,000 cases with a record of ulcers, 96 per cent of them men, those who had been medically treated, without an operation and without having had a hemorrhage, were found to have had a relatively favorable mortality experience during the 15 years covered.

On the other hand, those with a history of surgically treated ulcers had a materially higher than average mortality experience, despite advances in surgical technique. Also, those unoperated upon, but with a history of hemorrhage, appeared to be somewhat poorer than average risks.

It was found that three-fourths of the total ulcer cases were duodenal, the balance being gastric.

Another section of the study, covering persons with gallbladder disorders, indicated that such impairments are very more frequent among women than among men, but that where reports of the attack were over three years prior to the beginning of the study, such persons showed about normal mortality. Cases with an attack within a year or two of application for a policy showed somewhat higher than average mortality.

Policyholders with a history of gallbladder disorders experienced a slightly higher than average mortality from heart disease, which is in line with clinical observations pointing to some association between gallbladder disorders and coronary artery diseases.

The study also showed a decrease in maternal mortality related to pregnancy. The women pregnant at the time of policy application between 1945 and 1949 had an extra first year death rate of only 0.2 per 1,000, about one-tenth that of 10 years earlier. The extra mortality was higher at the older ages.

Medical Treatment of Portal Cirrhosis

Lipotropic agents are difficult to evaluate in humans. If the patient has a good appetite I feel they are not needed as a therapeutic agent. Clinically the best reports have been made on patients who have been found to have enlarged, fatty livers. In the absence of fat or enlargement of the liver due to fat it is very doubtful that lipotropic agents have any value at all.—Carl W. Kumpe, M. D., Covington: *J. Kentucky State M. A.*, 52:510, July, 1954.

An Experience with the Large Routine Chest Film In a Rural Hospital

J. W. BOYD, M. D.

The Author

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IN this era in which the lay press and various medical groups are persistently advocating routine, periodical physical examinations the physician now, more than ever before, has an excellent opportunity to discover early lesions. It is often said that no physical examination is complete without a chest roentgenogram. It is also well known to every physician that our best chances to cure disease are in its silent phase or when it is not causing symptoms, as this is usually a very early stage when it responds best. This is particularly true in tuberculosis and lung malignancy.

The Joint Committee on Diseases of the Chest define routine chest examinations as those examinations which are conducted to screen persons with abnormal changes of the chest from persons with normal chests. The patients with advanced disease do not concern us as much as the patients with the minimal disease. The former group will seek medical advice because of the distressing symptoms, but the latter will walk the streets with a minimal lesion, unknowingly jeopardizing their own lives and the lives of others about them.

For mass chest surveys the 35 mm., 70 mm., or the 4 by 10 inch stereoscopic films are available, as well as the full size film or 14 by 17 inch. Survey chest x-rays either in hospitals or in the general population are approved as a screening device if conducted by agencies which utilize well qualified professional and technical personnel and which make sincere efforts to send the positive individuals to qualified local physicians or clinics for proper follow-up.

Finding a chest lesion is only the beginning of the screening process. It is often difficult to differentiate tuberculosis from lung malignancy both clinically and radiographically. Any patient who presents an abnormal shadow on the screening film should have a more complete x-ray examination, including fluoroscopy, lateral projections and in many instances oblique projections. Tuberculin tests are essential. Sputum and gastric specimens for tubercle bacilli should be carried out. Cytologic examinations and bronchoscopy with biopsy should be done if a lesion indicating that such a diagnostic procedure is warranted.

PRIMARILY A SCREENING PROCESS

It should be emphasized that the admission chest film for the most part is a screening process and not diagnostic. In recent years, since the microfilm has been in use, numerous abnormalities of the heart and great vessels have been discovered which may have otherwise been overlooked had it not been for a screening procedure.

It was decided by the hospital board, administrator and medical staff of Detwiler Memorial Hospital, Wauseon, Ohio, in November 1952 to do routine admission chest films on all patients over 12 years of age, admitted for a period of 24 hours or more. Only one examination would be done on the same patient in a six month period regardless of the number of admissions of that patient in that period.

As the hospital has only 60 beds with approximately 3000 admissions yearly, it was felt that the expense incurred for the installation of a microfilm unit was not practical. It was agreed to use the large film or 14 by 17 inch. A fee was to be charged which would cover the expense of the radiology department but which would not discourage patients from having the examination.

THE IMPORTANCE OF PHYSICIAN-PATIENT COOPERATION

An interested and educated staff are a necessity if this type of program is to be successful. It is equally important that all of the hospital personnel understand the purpose and co-operate in the program. The examination was not mandatory, but each staff physician was to explain to his patient the value of the examination and that such an examination was available. Obviously a perfect record cannot be expected in this type of program, but we feel that at least 95 per cent of the patients in the foregoing category obtained the chest roentgenograms. Only three patients refused to have the examination from a cost standpoint in the twelve month period.

It is important that the patient receive the examination as soon as possible after admission, both for the protection of the hospital personnel and for effectiveness of follow-up if a lesion is discovered. The value of the procedure is also dependent on the extent to which the recommendations of the roentgenologist for further investigation are followed in order to establish a final diagnosis.

Statistics have shown that the incidence of

Submitted December 16, 1953.

tuberculosis is higher in patients in general hospitals than in the general population. It has also been shown that tuberculosis is higher in pregnant women than in the general population. It is often difficult to obtain an admission film on an obstetrical case. Therefore, it is advised that the attending physician refer his maternity cases to the hospital for a chest film during pregnancy, preferably during the last trimester.

In a twelve month period a total of 1205 admission films were taken. The films classed as "routine" do not include patients with chest complaints or patients suspected of a chest disease. Of the 1205 films taken, 133 or 11 per cent, presented some type of significant abnormality or finding.

TABLE 1—ANALYSIS OF LARGE ADMISSION CHEST FILMS

	No.	%
Abnormalities of the heart and great vessels	61	46
Rib abnormalities (all were cervical ribs except metastatic destruction in one case)	11	9
Diaphragm abnormalities	5	4
Lung disease—includes pneumonia, tuberculosis, bronchiectasis, fibrosis due to infection or occupation	50	38
Neoplasms	6	5

It must be stressed that the figures in Table 1 represent roentgen diagnoses only and that only a small number of these have been proven to date.

The first group of figures is most striking. The abnormalities of the cardiovascular system consisted largely of enlarged hearts or a cardiac configuration suggesting rheumatic heart disease. All films were taken at a 72 inch distance so that cardiac enlargement and cardiac configuration were readily recognized. Schwartz and Berman,[1] in a survey of 10,549 persons in Cincinnati, found 486 (4.6 per cent) abnormal cardiac silhouettes on the small roentgenograms. Slattery[2] states that many abnormal hearts are not detectable, or are missed, in interpretation of the chest microfilm. He does not advise the small film for detection of heart disease. Our study, although of a small number of cases, shows a much larger incidence of abnormal heart silhouettes.

COMPARATIVE FINDINGS

In the Minneapolis survey[3] of 1947 a total of 301,513 people were examined with the 70 mm. film. Of this number, 3.4 per cent were "positive" or represented some type of abnormality. There were 96.6 per cent negative. This survey was undertaken by the Minneapolis Health Department and Hennepin County Health Society. The suspected tuberculosis was 2 per cent while other suspected diseases were 1.4 per cent. In the Bronx Survey[4] of 1947 a total of 1,256 patients were examined on the 14 by 17 film. There were 131 or approximately 11 per cent of the cases called "positive" by one or more readers as compared to 1,205 cases with 133, or 11 per cent, "positives" in our survey.

The diaphragm abnormalities consisted of eventration of the diaphragm or suspected paralysis. The incidence of cervical ribs is high as compared to a study at the Mayo Clinic in which there were 303 cases among 540,413 cases or .056 per cent.[5]

Christie[6] reports a series of over 440,000 patients studied with the 70 mm. film. He reported a total of 3.8 per cent abnormal findings. These included definite and suspected tuberculosis as well as cardiac cases and other pathology.

It can be seen from the previous statements that a routine chest x-ray discloses a higher percentage of abnormalities than any other single routine hospital laboratory examination. There is also a definite increase in the number of lesions detected on the large film (14 by 17) as compared to the microfilm. However, the microfilm is still undoubtedly the most satisfactory and economical method in large screening processes.

The large film must be considered in hospital screening since the advantages are much greater. It is felt that the size of the hospital makes no difference. This survey has emphasized the importance of the routine admission film.

A community-wide chest x-ray program is a tremendous undertaking. Large numbers of people and organizations are involved. The community-wide survey represents a unique opportunity for a community to rethink its tuberculosis and cancer control program. It can be the starting point for an all-out effort to eliminate tuberculosis and an important stride in conquering lung malignancy. The success of the survey depends upon the breadth of understanding and exchange of ideas which the survey itself engenders. Around the conference table of survey management sit the private physician, the health officer, the public health nurse, the social worker, the tuberculosis association director and each in contributing his own point of view broadens that of the others.

The co-operation of all hospital personnel cannot be over emphasized. As revealed in the foregoing the co-operation of the medical staff is tantamount. The investment of a few minutes of the physician in explaining to the patient about this, and the expenditure of a relatively small sum of money on the part of the patient, may pay great dividends in years of life.

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Iron-Deficiency Anemia

A Pediatric Review

CARL WEIHL, M. D.

THE PROBLEM

INTEREST in the anemias of childhood has been stimulated in the past decade chiefly by the discovery of the isoimmunologic basis of erythroblastosis fetalis, and by the introduction of exchange transfusion in its treatment. In addition, more recent knowledge of the basic structure of fetal and human hemoglobins has led to a renewed interest in the problems of sickle cell anemia and the sickle cell trait. In contrast, interest in the other forms of anemia in childhood has been desultory and the progress rather meager.

Perusal of the literature might indicate that erythroblastosis and sicklemia constitute the bulk of the anemias seen in children, and yet nothing could be more erroneous. Careful study of the records of large outpatient groups indicates that the anemia associated with iron deficiency, while not as dramatic in its impact on a hospital service or as serious from the point of view of mortality rates, constitutes the great bulk of the clinically apparent anemias of childhood. In addition, further investigation of the records clearly shows that the problem of iron-deficiency anemia has implications and ramifications rarely mentioned in the textbooks and often neglected by the casual observer.

Clinically, iron-deficiency is seldom seen in the first six months of life, and then chiefly as a result of prematurity or multiple births. The great bulk of cases, in our experience, occurs during the second year of life, although the disease is not uncommon toward the end of the first year. In all of these patients the anemia is the direct result of decreased blood production associated with a deficient supply of iron.

ITS ORIGINS

The basic causes of iron-deficiency anemia in childhood are well known and rather easily elucidated, although in any individual case the etiologic factors often overlap. In the case of the anemias appearing in the first six months of life, the fall in hemoglobin is usually a prolongation and exaggeration of the "physiologic anemia" characteristically seen in all infants during the first three months of life. It occurs most commonly in infants who were born prematurely or as the result of a multiple birth.

Contrary to popular belief, the iron stores of a premature infant at birth are not low, in relation to his body weight. But, since he gains weight relatively rapidly, when compared to a term infant, the iron stores are inadequate in relation to his total weight gain. Since the introduction of dietary iron is apt to be delayed in the premature infant's feeding regimen, he becomes dependent, after six weeks of age or so, on medicinal iron to prevent the prolongation of his physiologic anemia. Thus several factors —a relative deficiency of iron, a rapid rate of growth, an immature hematopoietic system, and a delayed introduction of dietary iron—combine to produce the anemia seen in infants who were born prematurely.

In the anemias which appear during the latter part of the first year of life and which abound during the period from 12 to 24 months of age, several distinct etiologic factors can be easily recognized by the clinician.

During the second half of the first year infants of mothers who themselves were anemic are apt to become anemic, because of deficient iron reserves imparted to them *in utero*. This hypochromic anemia can be prevented by the administration of iron to the mother during pregnancy.[1] Because of the improvement in pre-natal care and the general appreciation of the frequent need for supplementary iron during pregnancy, anemia in infants as result of maternal iron deficiency is becoming much less common.

A second, and relatively more common cause of iron-deficiency anemia in this older age group is the occurrence of repeated acute infection, or the existence of some chronic illness. Clinically, repeated upper respiratory infections, which are so common during the period from 10 to 24 months, seem to be the most frequent offender in this respect. While it was formerly believed that impaired intestinal absorption of iron was the cause of the anemia associated with infection, more recent studies indicate that the problem is one of utilization of iron.[2]

The third, and probably commonest, cause of iron deficiency in children is the simple failure to provide an adequate intake of dietary iron. While simple "nutritional anemia" may undoubtedly

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occur, it is usually the combination of recurrent acute infections with an inadequate dietary intake of iron that accounts for the bulk of the cases seen during the second year of life. An examination of the feeding habits of clinic patients reveals that basic economic and cultural patterns definitely predispose to the development of iron-deficiency anemia.

Particularly in large urban areas, where poor housing is a common corollary of poverty, a high incidence of respiratory infections is seen among the "toddler" age group. Poor sanitary facilities, overcrowding, and frequent exposure to infection constitute an easily recognizable triad in the child who "keeps a cold all winter." Cultural phenomena relating to an inadequate diet unfortunately are operative in this same economically deprived group, and result in prolongation of bottle feeding past the first year, with a gradual increase in milk intake to the exclusion of solid foods. Inasmuch as milk is relatively poor in iron, a hypoferric state soon ensues. During the first eight months of life these children are usually surprisingly well fed; since the introduction of relatively inexpensive, homogenized infant foods (cereals, vegetables, meats) it has been relatively easy for a mother to give her child an adequate dietary intake of iron.

When the child begins to prefer "table foods" the trouble usually starts, for the family diet is often grossly deficient in iron, and the child then gradually develops a hypoferric anemia. As a result of the anorexia that accompanies the iron-deficiency anemia, solid foods gradually disappear from the child's preferred diet, and he then begins to subsist almost exclusively on milk. The daily consumption of two quarts of milk and almost no solid foods can often be predicted on examination of most of these infants with a moderately severe iron-deficiency anemia.

ITS DETECTION

The clinical diagnosis of iron-deficiency anemia in early childhood requires only an appreciation of its frequent occurrence, an insight into the behavioral and dietary patterns that accompany the disease, and the appearance of pallor in the patient. The disease develops very slowly, and the parents are usually unaware that the behavior, food habits, or appearance of the child are at all abnormal. As the pallor develops and becomes more marked, the child becomes extremely irritable, and is even more refractory to guidance and interference than the one to two year old normally is. The appetite gradually declines, so that the diet eventually consists only of milk; attempts to "force feed" solids by an anxious parent only intensify the problem, and usually result in vomiting.

Occasionally, this behavior results in consultation with a physician; more often, such behavior is almost so common as to be culturally "physiologic," and it is only on a routine visit or because of an acute infection that the physician sees the child, elicits the typical history, and detects the pallor. Examination of the skin is often misleading in attempting to evaluate pallor, and recent studies in England indicate that there is very little correlation between the clinical assessment of the degree of anemia and the actual hemoglobin level. However, examination of the ear lobe and the palpebral conjunctiva can give a rough intimation of the presence of anemia, and the clinical impression should be confirmed in all cases by a complete blood count; a hematocrit is an additional aid, though not entirely necessary and usually difficult to obtain because of the necessity of venipuncture.

The blood typically shows a fall in hemoglobin (to levels ranging from 3 to 10 gm. per 100 ml.), and the red blood cells, slightly to moderately decreased in number, are both hypochromic and microcytic. A stained smear occasionally shows nucleated red blood cells, and not infrequently abnormalities of size and shape are encountered.[3] The blood indices show a lowering of the mean corpuscular volume (70 to 80 cubic microns), and a decrease in the mean corpuscular hemoglobin (10 to 20 micro-micrograms). Bone marrow studies, when done, demonstrate a normoblastic hyperplasia.

ITS IMPLICATIONS

As indicated previously, iron-deficiency anemia is so common that in a large urban indigent population its occurrence is frequent enough to be the norm rather than the variant. While the course of the disease is usually benign, it may be quite prolonged if there is no alleviation of the underlying cause. Although mortality from iron-deficiency anemia is extremely rare, the morbidity rate is high, and on closer inspection is found to be associated with an exacerbation of several symptoms and syndromes, both emotional and organic, which occur during this age period.

(1) The physical signs and symptoms of the disease are often confused with other causes of anemia, and must be differentiated by laboratory examination from more critical causes of anemia.

(2) Emotional problems in handling these children are intensified because of the extreme irritability, restlessness and intractability which they exhibit. Problems in discipline are increased many times and parental frustrations increase to a point of inadequacy, since not even the most careful handling of the child will eliminate his refractoriness.

(3) The attitude of the child with iron-deficiency anemia to food is influenced by his organic anorexia; his parents, unable to fathom his dislike for solids, not infrequently start forced feedings. While the child invariable wins this initial battle, he ultimately loses, inasmuch as his

attitudes to food and mealtimes in later life are in great part determined during this period.

(4) Associated with iron-deficiency anemia is the frequent occurrence of pica (abnormal appetite), which, in our experience, has all too often included a diet of putty, plaster, wall paper, and peeling paint. The logical consequence of this has been the appearance of chronic lead poisoning; no less than 40 cases have been treated in Cincinnati in the last five years alone![4] The high mortality rate and the severe sequelae noted in these cases of lead poisoning indicate that the elimination of pica is a major medical problem until legislation to remove lead pigments from paints can be enacted.

ITS TREATMENT

The prevention of iron-deficiency anemia is the most logical and successful treatment of all. This can be readily accomplished in several ways:

(1) An adequate supply of iron should be given to every pregnant woman throughout her pregnancy.

(2) Increased efforts should be made to reduce prematurity.

(3) Dietary iron should be introduced into the diet by the sixth week of life, preferably in the form of cereal; the early subsequent addition of egg yolk and meat will then supply the infant with all the iron he needs.

(4) The transition from "baby foods" to "table foods" should be preceded by instructions from the physician on the importance of maintaining an adequate daily intake of cereal, fruit, vegetables, egg, and meat. This is also an opportunity to improve the diet of the entire family, using the infant's needs as a lever.

(5) The intake of milk should be limited to not more than 32 ounces in 24 hours. The frequency of overindulgence in milk to the exclusion of iron-containing foods cannot be emphasized too strongly.

(6) Where limitations of parental understanding, cooperation, or economic circumstances indicate, prophylactic medicinal iron should be given every day, in much the same fashion as prophylactic vitamins are administered. (A single daily dose of 5 cc. of elixir of ferrous sulfate is adequate for this purpose.)

Once iron-deficiency anemia is established, treatment with medicinal iron in full therapeutic doses should be instituted; however, in the presence of infection, the utilization of iron is interfered with, and therapy should not be instituted immediately, unless the course of the disease is a long one, or its recurrence too frequent.

Iron is best administered to these small children in the form of the U. S. P. elixir of ferrous sulfate, an effective, palatable, and inexpensive preparation. The total daily dose is 0.5 gm. (7½ grains), administered as one teaspoon of the U. S. P. elixir three times daily. The reticulocyte response and subsequent hemoglobin rise are more satisfactory if the iron is given between mealtimes; milk should not be used as a diluent because of its high phosphate content, which decreases the absorption of the iron.

Treatment should be continued for a minimum of 30 consecutive days. A rapid increase in appetite, with a concomitant decrease in irritability, occurs soon after the institution of treatment. It is mandatory, however, that parental feeding attitudes and dietary understanding be corrected prior to this, in order that the child may then begin to eat happily a diet that is adequate in iron content, as well as in the other constituents of a normal, well balanced diet.

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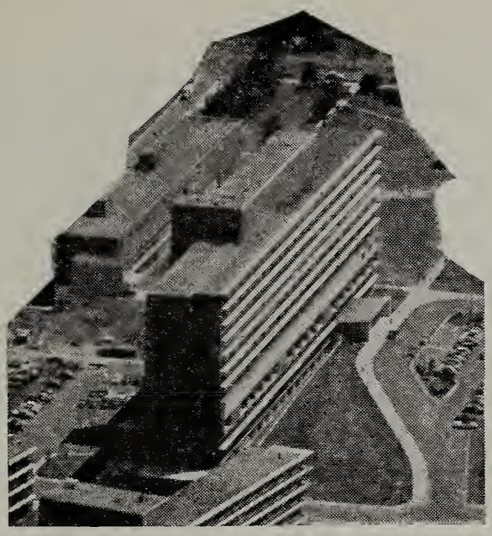
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Housewives' Eczema

Eruptions upon housewives' hands are among the most common skin disorders seen in the physician's office . . . The overconscientious, tense, restless woman who is preoccupied with cleanliness, routine, and order suffers a greater incidence of hand dermatitis than her more phlegmatic sisters.

SOAP AND WATER: These are the most common applications to the skin. Although soap and other detergents are considered by the laiety to be the cause of most hand eruptions, we must keep in mind that water, and water alone, is probably enough to account for the difficulty. Immersion of the hands in water, with insufficient drying, produces "chapping" of the skin. The horny protective surface of the skin becomes hydrated, loses its elasticity and is easily fractured. One sees this commonly over the knuckles, an area under constant tension from flexing the fingers.

These same factors operate at the usual site of onset of housewives' eczema, the ring finger base. Here there is a space beneath the jewels of the wedding and engagement rings which accumulates soap, water and other household debris over a period of months. This area of skin remains wet when the remainder of the skin is dried. Constant friction of this wet mass against the skin produces irritation and provides a source from which the hand dermatitis spreads.—Henry M. Lewis, M. D., Denver: *Rocky Mountain M. J.*, 51:593, July, 1954.



A Case Record

From The University Hospital
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Presented by: N. O. Rothermich, M. D., and Emmerich von Haam, M. D.
Burr M. Hathaway, M. D., President
Edited by: E. von Haam

PRESENTATION OF CASE

A 62 year old white male reëntered University Hospital with the chief complaint of shortness of breath and weakness 16 days after he had been discharged from the isolation ward of that hospital following a 10 day period of hospitalization. A diagnosis of arteriosclerotic cardiovascular disease and pulmonary emphysema with fibrosis of unknown etiology had been made.

Ever since he started working as a leather cutter at the age of 14 the patient had had a chronic cough productive of about a half-cup of thick yellow sputum daily. He had had exertional dyspnea for many years which had become worse in the last 7 to 8 years. He had also had increasing orthopnea and paroxysmal nocturnal dyspnea in the past two years and had been forced to sleep sitting up. His ankles had begun to swell about nine months ago and at the time of his first admission the swelling had extended to his knees. Chronic low back pain had been present for years and recently had kept him from sleeping. Except for nocturia of 1 to 2 times each night he had no urinary symptoms.

During the patient's first hospitalization he was digitalized and received mercurial diuretics and low sodium diet, to which he responded well. Bronchoscopy at that time revealed chronic bronchial inflammation and a biopsy of the thickened mucosa at the entrance of the left lower lobe revealed acute focal inflammation. Sputum cultures were consistently negative for acid-fast bacilli. The patient was considerably improved when discharged. He was followed-up in the Outpatient Clinic and was progressing satisfactorily on routine cardiac therapy. In the second week after discharge he was allowed to eat salt because of increasing symptoms of weakness. He then developed a marked increase in his dyspnea with swelling of his feet and cough productive of purulent sputum.

Physical Examination: The patient was a well-developed, emaciated, markedly dyspneic, cyanotic, elderly white male. The blood pressure was 120/80, respiratory rate 48 per min., pulse rate 104 per min., temperature 99°F. The skin showed poor turgor and was pallid. He had moderate kyphosis and scoliosis.

The chest had an increased anteroposterior diameter and was hyperresonant to percussion throughout. There were moist inspiratory and expiratory rales throughout with somewhat fewer rales at the apices. There was some dullness over the right apex anteriorly on percussion. The cardiac border was at the left anterior axillary line. The liver edge was two fingerbreadths below the right costal margin. The prostate was slightly enlarged and firm. There was 3 plus bilateral pedal edema and cyanosis of the nail-beds. The remainder of the physical examination yielded no significant findings.

Laboratory Data: The admission blood count showed 4.78 million red blood cells, 14.7 grams of hemoglobin, 13,000 white blood cells with a differential of 87 per cent neutrophils, 6 per cent lymphocytes and 7 per cent monocytes. The urine had a specific gravity of 1.020, a *p*H of 5.5, a protein content of 120 mg., a trace of sugar, and showed microscopically 0 to 3 casts, 8 to 18 white blood calls and 30 to 40 red blood cells per high power field. The blood serology was negative for syphilis. The blood urea nitrogen was 45 mg., the total protein 5.4 with an A:G ratio of 1.7:1, the CO_2 combining power was 54.5 vol. The sodium content of the serum was 147 meq., the potassium content 7.2 meq. and chlorides 101.5 meq. Several blood cultures were consistently negative. Sputum culture revealed alpha streptococci, diphtheroids and Staphylococcus aureus. Cultures for acid-fast bacilli were negative.

An electrocardiograph on admission was interpreted as showing digitalis effect and probable right ventricular enlargement.

X-Ray Data: Chest roentgenograms at the time of the first admission showed a diffuse

pleural reaction and fine streaked and mottled density consistent with an infiltration of a chronic type, possibly tuberculosis. The transverse diameter of the heart was increased approximately 25 per cent. A repeat chest film four days later revealed a decrease in size of the cardiac silhouette with marked clearing of the congestion of the lung fields, considerable resorption of the pleural effusion, and moderate emphysema. At the time of the second admission a portable chest film when compared with previous films revealed no areas of new infiltrate.

Hospital Course: The patient continued to be dyspneic. He was placed on combiotic® and routine congestive failure therapy but manifested little improvement. When he was put in an oxygen tent he became comatose and was therefore given oxygen only intermittently. His temperature remained at 99 to 100°F. Because of the area of infiltration of the left apex the patient was transferred to the isolation ward on the third hospital day. Because of the hyperpotassemia he was started on testosterone in an effort to fix the potassium in the cells. About five hours after the patient was transferred to the isolation ward he expired suddenly.

CLINICAL DISCUSSION

Dr. N. O. Rothermich: This patient was a 62 year old white male whose complaint was that he had been going downhill—a remarkable complaint which tells you a lot—"been going downhill." It means that he has been slipping for a long time, and right away you can rule out acute illness. A man does not go downhill when he suffers from lobar pneumonia or coronary occlusion, so just on this one initial complaint you can place this man in the category of chronic diseases. He said that he had had a cough as long as he could remember and he attributed it to a post-nasal drip which had bothered him for many years. His cough was usually productive of a whitish phlegm.

Eighteen years ago he had been off work for 14 weeks with what he said was pus on his lungs. He recovered from this and it is noteworthy that he did not miss a single day's work until two weeks before he went into the hospital. I think that this is a very important piece of information because in that span of some 18 years we must assume that whatever he developed was certainly very slow and insidious in its progression.

The fact that he denied any wheezing asthma is very important in this story. About one year prior to admission he was first told that he had heart trouble when he noted that his legs had begun to swell. For many years he had noted dyspnea on exertion and palpitation and had to quit his favorite sport of hunting because of this complaint.

It is said that he had had episodes of paroxysmal nocturnal dyspnea for several weeks prior to admission. When you say "paroxysmal nocturnal dyspnea" you imply a certain specific disease entity and many episodes have been called that which have not been that. When someone tells me that a patient has had paroxysmal nocturnal dyspnea I assume that the patient went into acute left heart failure in the middle of the night and was awakened suddenly gasping for air and as soon as he got into the upright position was somewhat relieved. People can be awakened with acute bouts of asthma and they will wake up gasping for air, go to the window, etc., and sometimes fall, but that is not paroxysmal nocturnal dyspnea. People with chronic lung disease can wake up in the middle of the night short of breath and have orthopnea, but I don't believe that falls into what we understand as paroxysmal nocturnal dyspnea either. So I raise the question here whether this is a true observation. It is after all only a quotation of the patient and an interpretation by the doctor. He said that he had had orthopnea for 7 to 8 years previously and had to sleep in upright position during all this time. That seems to have been real orthopnea.

About three weeks before he went to the hospital he developed what he thought was "flu"—an acute respiratory infection, we will assume, and following this he rapidly grew weaker, his sputum changed to a thick yellow and increased to about a half-cup a day. He never coughed up any blood but he became rapidly more short of breath, particularly on exertion, so that he was hardly able to make any movements at all, even to feeding himself. He denied at that time any chills, fever or night sweats.

His physical findings at the time of admission: He was a pale, emaciated white male in very severe respiratory distress, with marked cyanosis of his lips, ears and nails. There was a deformity of the chest with an increase in the anteroposterior diameter, and there was a marked dorsal kyphosis and moderate scoliosis. The lungs were hyperresonant at the bases and there was no dullness. The breath sounds were reduced over the lower half of both lungs with bursts of late fine rales on inspiration. There were more coarse inspiratory rales heard above that level but no expiratory wheezes were noted. The heart was enlarged on physical examination and the second pulmonic sound was said to be accentuated. The liver was markedly enlarged. There was 4 plus pitting edema of both lower extremities. The neurological examination was negative.

What do we have before us? We have a man who had either heart disease or lung disease or both. Of that we can feel certain. I think we can exclude practically any other organ system. We can also assume that the illness of his heart or his lung is a chronic disease; it did not happen

acutely, it developed over many, many years and it has been aggravated apparently by the onset of a recent respiratory infection which the patient interpreted as flu.

First, let us assume that he had heart disease. He certainly had right heart failure at the time of admission. Now did he ever have left heart failure? He may have, but if he had we cannot explain how his left heart failure could have caused him his respiratory difficulty for 18 years and allowed him to continue work without a single day's loss up to two weeks prior to admission. If he had mitral valvular disease we should have heard some kind of murmur surely, and also we would want some better history of rheumatic disease. So I would like to state at this point that his heart disease is probably right ventricular failure and I would be inclined to believe that he has primarily chronic lung disease which has given him a cor pulmonale with subsequent right heart failure.

Now what lung disease could be possibly have? If we accept the history as related here, consider his symptoms, accept the statement that he has had orthopnea requiring him to sit up to sleep for 7 to 8 years, we must think of a very slow and very insidious type of pulmonary disease. I think we can rule out tuberculosis or any of the fungus diseases since they would certainly run a more decisive course over that period of time. You would be tempted to assume that this man had chronic bronchial asthma and developed the usual emphysema and bronchiectasis, but he himself stated that he has not had wheezing asthma and most patients know when they have asthma. We therefore would have to make the diagnosis of asthma in the face of contrary evidence.

So we must consider that what has happened in his lungs has been of a slowly scarring nature, that has literally strangled him from within, an increasing deposition of fibrous tissue which has impaired his aeration, and we know that people get along remarkably well with tremendous degrees of fibrosis of the lung and reduction in their vital capacity. We don't want to say simply that he had pulmonary fibrosis.

We can perhaps say that he had pneumoconiosis. What kind of pneumoconiosis? Certainly this man did not have anthracosis. Of course we could think of silicosis in a patient with this kind of a history. Silicosis can be a very chronic disease. However, this man had no exposure and exposure is of utmost importance in the diagnosis. The State of Ohio will not recognize a diagnosis of silicosis without an adequate history of exposure. I don't think there is adequate history for asbestosis either.

One disease that we have to admit as a possibility is berylliosis. Beryllium when it is inhaled has two different effects on the lung. One of them is an acute pneumonitis from which the patient rapidly recovers, and the other form is a chronic process which is peculiar and apparently represents a hypersensitivity reaction and may go on for many years in a very slowly progressing form. Berylliosis is said to have occurred in people who have had only one single exposure and to a very small concentration. Berylliosis looks exactly like tuberculosis in its histopathologic appearance, and it is a slowly strangulating disease. It is said to produce severe degrees of right heart failure invariably. I do not know how one could possibly make the diagnosis in a living individual except by pulmonary biopsy.

INTERSTITIAL FIBROSIS?

We might think that this individual had a primary interstitial fibrosis of the lung, which is a disease of yet unknown etiology consisting of an increasing deposition of fibrous tissue in the alveolar walls and producing a so-called alveolocapillary block. The one way of recognizing this condition is by oxygen saturation studies before and after the inhalation of oxygen, which was not done on this patient. So I would be inclined without going any further to make a diagnosis of chronic pulmonary fibrosis, possibly of so-called primary interstitial fibrosis of the lung, or of berylliosis.

As regards some of the diseases we can exclude: The tuberculosis cultures were negative on four different occasions, which should fairly well rule out tuberculosis of the lungs. The purified protein derivative tuberculin test was negative on two trials. The histoplasmin test was negative. They even applied some Boeck's antigen for sarcoidosis, but the result of that was negative. The blood globulin was normal, which I think also speaks against sarcoidosis. A bronchoscopic examination was done and a specimen for biopsy of inflamed bronchial wall was taken and showed only a focal bronchial inflammation. Sputum cultures for fungi and pathogens were negative. The electrocardiogram is interesting in that it showed constant shift of the transition zone to the left, which I am told is always indicative of right heart enlargement.

CLINICAL DIAGNOSIS

1. Pulmonary fibrosis of undermined etiology with chronic emphysema.
2. Cor pulmonale.
3. Congestive failure.

GENERAL CLINICAL DISCUSSION

DR. J. L. MORTON: From the chest plates it is my opinion that this patient had chronic pulmonary emphysema, that he had cor pulmonale and heart failure, and that his heart failure improved due to rest and certainly not to oxygen.

DR. ROTHERMICH: Do you think that the heart size was normal?

DR. MORTON: I considered that it was 25 per

cent over that expected for the patient's height and weight, that it was a decompensated stress heart.

DR. THOMPSON: What about the urinary findings?

DR. ROTHERMICH: I think this represents a terminal event that I did not pay too much attention to. The chart shows that he had a catheter inserted for some time and that there was a lot of trauma from it and bleeding around the catheter. I would assume that he may have had some urinary tract infection which he did not have on his first admission.

DR. RYDER: Dr. Rothermich, there was one question that was not brought out, about oxygen narcosis which occurred in this man and which might be worth discussing.

DR. ROTHERMICH: I would like to point out that for people who have been chronically hypoxic for some time the administration of oxygen can produce apparent toxicity, narcosis or even manic symptoms. Some claim that it is due to the toxicity of the oxygen, others feel that it is due to an alteration of the carbon dioxide concentration.

DR. VON HAAM: Can you prove hypoxia by instruments now clinically?

DR. ROTHERMICH: Sure, it is simple. An arterial oxygen saturation would have been just a nice test had it been done.

DR. VON HAAM: Why is it not done more often?

DR. RYDER: I might point out that this man came in moribund. I don't think that point has been brought out. Physically this man was extremely cyanotic.

MEDICAL STUDENT: What is your diagnosis of the cause of death of this man?

DR. ROTHERMICH: I don't think you appreciate how these people with their very low pulmonary reserve teeter on the balance for years. They can get along fine just so long as nothing happens to their respiratory system. But let them happen to have a bout of bronchitis and they will die. I am surprised that he got along for 7 or 8 years with orthopnea, sitting up at night all night long for 7 to 8 years. That is a very unusual history.

DR. MORTON: That fellow wants to get you to make a differential diagnosis of the cause of death so that we can find out that you are wrong.

DR. ROTHERMICH: I don't know why this man went out, I think it is very unimportant. I think the long disease entity that he had is what we should be concerned about, not what shoved him off the cliff.

PATHOLOGICAL DIAGNOSIS

1. Chronic bronchitis with bronchiectasis and bronchial asthma.
2. Chronic pulmonary emphysema.
3. Cor pulmonale.
4. Right heart failure.

PATHOLOGICAL DISCUSSION

DR. VON HAAM: We chose this case because you will meet this type very often in your practice. At autopsy we found a poorly nourished individual weighing about 125 lbs. There were 500 cc. of fluid in the right pleural cavity and much less in the left pleural cavity. The heart weighed 350 grams. It appeared dilated, particularly the right ventricle. The wall of the right ventricle was thickened and measured 3 to 4 mm, as compared to 2 to 3 mm. in a normal heart. The dilatation makes this thickness even more significant. The right auricle was distended also. The left ventricle was comparatively small, and the coronaries showed a few atheromatous plaques but no particular evidence of severe arteriosclerotic heart disease.

The right lung showed an adhesive fibrous pleurisy with thickened plaques particularly over the apex, and there was definite scar tissue in the apex which had a thickness of 1 cm. The lung otherwise felt fibrous and showed an emphysema which was not of the ballooning type but that which shows loss of elasticity. The bronchi of the lower lobe were definitely distended and completely filled with thick yellow pus. The left lung was similar to the right. Again it showed mild anthracosis with scarring of the apex. This lung showed a severe chronic purulent bronchitis with bronchiectasis of the bronchi of the middle and upper lobes.

The liver was normal, with some nutmeg design. There was a normal pancreas. The gastrointestinal tract showed some diverticulosis. The kidneys were perfectly normal. The bladder showed an acute hemorrhagic cystitis which was obviously caused by the retention catheter. The prostate was not particularly enlarged. The brain showed nothing of note.

Microscopic Examination: Sections through the lungs show distended alveoli with little fibrous knobs at the ends of free-hanging septa. These fibrous knobs usually contain a sclerosed capillary. The small bronchioles are all dilated and surrounded by inflammatory granulation tissue. The large bronchi show a marked thickening of the basal membrane which to us is histological evidence of bronchial asthma.

The bronchial glands show definite evidence of mucoid hypersecretion. I would say that this patient's pulmonary difficulties were not so much caused by fibrosis of the lung, although some is present, but the principal lesion was a dilatation of the small bronchioles with obstructive hypersecretion in the larger bronchi. I gained the impression that this patient suffered from asphyxia by obstruction at the bronchiolar level and not from fibrosis of the alveoli as in pneumoconiosis.

You asked about the cause of death. Look at the acute congestion in the liver. We all know

that overdilatation of the right auricle will cause auricular fibrillation with very sudden collapse and death. The point I want to make in this particular case is: Can we differentiate clinically between the various causes of cor pulmonale? I feel that bronchiolar disease with asthma and bronchiectasis was in this particular case the primary and only cause for his cor pulmonale and cardiac death.

GENERAL DISCUSSION

DR. ROTHERMICH: This case pleases me a great deal because it does demonstrate a very common disease, one of the most common that you will run into, and I agree heartily with Dr. von Haam. I can say truthfully that before he showed the large bronchial section I had decided in my own mind that this man had asthma regardless of the history and regardless of the physical findings. I was sure of it when he had the chronic emphysematous changes in his peripheral lung fields, the bulbous ends to the broken alveolar walls without thickening of the alveolar walls, and the bronchiolitis which goes along so commonly with asthma and the bronchiectasis. It again points up the necessity for a good clinical history and I just can say that somebody did not talk to this man long enough or in detail enough to bring out the true nature of his complaints. Somebody converted his statements about his difficulty getting up at night into paroxysmal nocturnal dyspnea, and I feel certain in retrospect that those were attacks of asthma that he had.

DR. RYDER: When we are speaking of paroxysmal nocturnal dyspnea it is an entirely descriptive term and although it is commonly accepted that it occurs in hypertension and left ventricular failure, it can be used in asthma because it only means that it is nocturnal shortness of breath occurring in paroxysms.

DR. MORTON: If they had paid any attention to the heart measurements they would have recognized from the first time he was in that this was heart failure.

DR. RYDER: The man was recognized as being in heart failure on the first admission and was digitalized and treated with ammonium chloride. Later the man complained of weakness and it was thought he might be a low salt syndrome. He was advised to use salt, which he did, and consequently came back in in severe congestive heart failure.

DR. MORTON: So that big heart in his last picture did tell the truth, didn't it?

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Eat—Coming from the Anglo-Saxon word "etan," this word has many related and similar forms in other languages such as the German "essen," the Latin "edere," and the Greek "edein" —all meaning to eat. These words all probably spring from the Sanskrit word "adana," meaning food.

Heroin—This artificial alkaloid is di-acetyl morphine and was first prepared in 1898 by Dreser. The term "heroin" is a German trade name which was given to this drug to conceal its relationship to morphine. This name was chosen because the drug imparts a sense of grandeur and makes the taker feel like a hero or heroine.

Halitosis—A term literally denoting a "condition of breath." It is derived from the Latin word "halitus" meaning breath, plus the suffix "osis" denoting a condition of. The term originally used for bad breath was "halitus oris foetidus" and halitosis is a comparatively recent term.

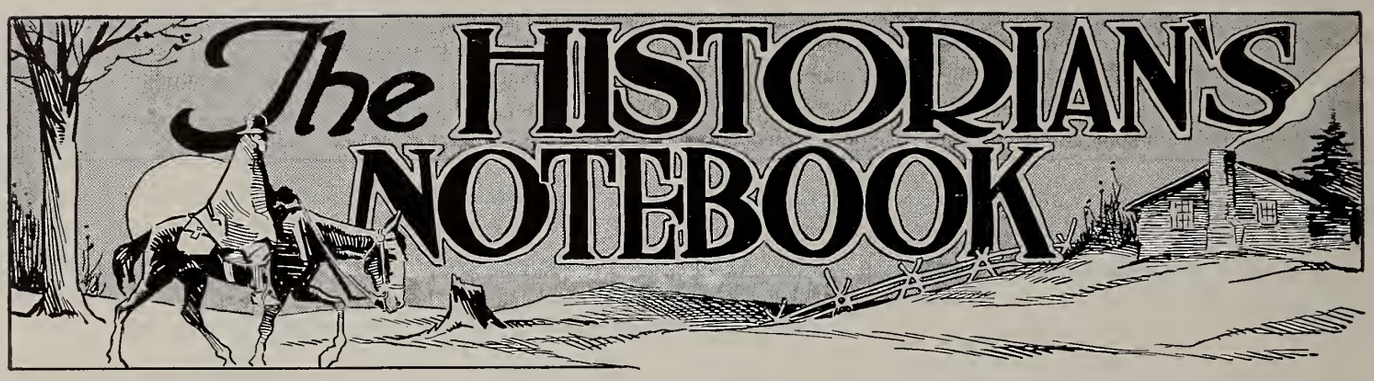
Eosin—This coal tar dye which is extensively used as a tissue stain was first prepared by Caro in 1871. This stain is so named because of its red or rosy color which supposedly resembles the color of the sunrise or dawn. The word eosin is derived from the Greek word "eos," or dawn. In Greek mythology Eos was the Goddess of dawn, corresponding to the Roman Goddess Aurora.

Eschar—Escharotic—These terms are of Greek derivation and come from the word "eschara" meaning a hearth or fireplace. By extension "eschar" came to mean the crust or scab on a wound caused by burning and the term escharotic came to mean a caustic or agent having the power to burn or sear the flesh.

Ephedrine—The Greek word "ephedra" was an old term for the buttocks and literally meant a sitting upon. The term came to be applied to a genus of shrubs commonly called the "horsetail plant." Ephedrine is an alkaloid obtained from the leaves of this plant. Under the name of "ma-huang," species of ephedra were used in China for many years. Ephedrine was introduced therapeutically in 1924 and produced synthetically in 1928 by Ko Kuei Chen, a chemist in Madison, Wisconsin.

Scalpel—This is a French word which is derived from the Latin "scalpellum" which is a diminutive of the Latin "scalprum," a knife or chisel. This in turn comes from the Latin word "scalpo," or I carve. Celsus, in about 30 A. D. in his book *De Medicina* always referred to the surgeon's knife as the "scalpellus."

—HARRY WAIN, M. D., Mansfield, Ohio.



A Report on Asiatic Cholera Epidemic*

To the Directors of the Ohio Penitentiary, Columbus, 30th November, 1849, By William Trevitt, M.D.

GENTLEMEN: Having been called by you, some what more than four months ago, to take charge of the hospital department of the penitentiary, in the capacity of it's medical officer, in consequence of the removal, by a melancholy dispensation of providence, of the late lamented Dr. Lathrop, the duty once more devolves upon me, to report the condition of the inmates of the institution, as far as regards the exercise of my profession.

This I shall do, as briefly as the subject will admit, and, at the same time, as fully and as faithfully, as my opportunities will allow, not incompatible with a report of this kind.

Since the last annual report, from this department, the worst apprensions of it's late medical officer, as then shadowed forth, have been more than realized, although he benevolently and fondly cherished the hope, that by cleanliness, the best practicable ventilation and a guarded diet, the dread ordeal would pass with comparative immunity.

From an examination of the register and prescription book, I find that the period of eight months commencing with the 1st of Dec. last to the 29th June, the health of the prisoners was more than usually good. From the same source of information, I learn, that for a few days prior to 30th June there was among the inmates considerable intestinal derangement, but not of an alarming character.

It may not be improper to remark here, that the cholera had prevailed fatally in this city for eight to ten days previous to it's appearance in this prison. The first unequivocal cases, occurred on 30th June, from which time events transpired, that spread alarm consternation and death among the panic stricken convicts and cast a deep gloom over our city and state.

On the morning of that day, at early dawn, in the then temporary absence of the medical attendant, I was summoned to the prison, two of the convicts had been stricken with the cholera, the disease had been upon them since the day previous, and so deeply fixed it's poisonous effects, that no human skill could avert it's fatal consequences, the livid countenance, the contracted brow, the sunken eye and the death sweats, proclained, in unmistakeable terms, the alarming character of the disease, which was now found within the walls of the penitentiary, these two died shortly, seven others, in the milder stage of the dread malady presented themselves for treatment on the same morning, all of whom, recovered.

In the afternoon Dr. Lathrop returned and by special request, I continued by attendance, for altho the epidemic had not yet made very fatal ravages, the strong tendency to diarrhea and the panic among the inmates of the institution were truly alarming. During the day we prescribed for fifty seven convicts, the most of whose cases were diarrheal but by early and careful treatment, none except the first named cases, assumed a dangerous form.

July 1st—Sixty two new cases, mostly diarrheal, no deaths.

July 2nd—Sixty three new cases, affected similiarity, no deaths.

July 3rd—Fifty four new cases, two deaths. On the evening of the 3rd Dr. Lathrop after spending the day in the hospital, in intense solicitude returned to his home and there was prostrated by the fearful disease, but from this attack he recovered.

July 4th—On this day I prescribed for one hundred and fifty one convicts up to four o'clock P. M. Upwards of eighty of these had copious rice water dejection, ten of them were in the stage of cramps, rice water vomiting and other

*Presented by J. H. Czatt, M. D., Modesto, California, in whose possession is the original manuscript.

symptoms of the most imminent peril, but, no deaths.

July 5th—Before five P. M. I prescribed for one hundred and thirty eight convicts, forty four of whom were new cases, in seven of these, violent cramps and rice water vomitings had come on, before they were placed under my observation, no deaths during the day, one at night.

July 6th—Debilitated by disease and depressed in spirits at the prospect before him and contrary to the service of his friends Dr. Lathrop returned to his post fully aware of the danger he incurred, he preferred to fall in the cause of humanity, and in the discharge of his duty rather than to seek safety by a course of conduct he considered inglorious to his profession, of which he was an honor in life, and to which he was a martyr in death. This day thirty new cases prescribed for, beside, those standing over from previous days. Three deaths.

July 7th—Twenty seven new cases, and five deaths.

July 8th—Twenty new cases and eight deaths. The disease had now prevailed in the prison nine days, and out of four hundred and twenty three convicts, there were prescribed for, three hundred and ninety six for cholera in some of it's stages or disease depending upon the epidemic influence, twenty one had died and nearly half of this number on this day, most of whose deaths were the result of relapses, almost every attendant had sickened, many relapsed and relapses were rapidly and alarmingly fatal, business was suspended, the convicts were turned from the workshops into the hospital, all the rooms of which were so crowded, as to render the atmosphere unfit for respiration, many of the officers were prostrated, and out of the whole number of convicts there were not men well enough to act as attendants. Convalescents were necessarily called to officiate in the capacities of nurse, cook, undertaker, and sexton, most of whom fell victims in the discharge of this service.

July 9th—It was on this day, that the board wisely approved of converting several of the workshops into additional wards, and also decided to call in the aid of additional medical gentlemen, the value and importance of whose kind attention can only be appreciated by those who witnessed and those who participated in their humane and timely assistance.

The unavoidable confusion, however, incident to such a change prevented me from procuring any correct memoranda of admission to the newly formed wards, the hospital proper, being alone under my immediate charge, so that my diary except as two deaths, was from this period imperfect until the time when the epidemic had so far subsided as to restore the sick to their original hospital quarters. There were twelve deaths this day.

July 10th—Twenty two died this day, the greatest number of deaths that had occurred during the prevalence of the epidemic, and from this period of time the number diminished regularly. On the evening of this day Dr. Gard who had kindly volunteered his services, and Dr. Lathrop care worn and almost exhausted with watching and anxiety returned to their homes and both sickened, Dr. Lathrop for the second time, neither of them ever again left his room, the former died the next day, and the latter on the following Monday the 11th.

NO. OF DEATHS

(July)	11th	16	(July)	18th	1
	12th	12		19th	1
	13th	7		20th	3
	14th	6		21st	1
	15th	6		22nd	1
	16th	3		26th	1
	17th	2		30th	1

On the 22nd day of July the epidemic had so far abated and the number of sick had so much diminished as to admit the convicts to their proper Hospital, from this time to the last of July there occurred eighteen new cases and three deaths.

By the foregoing diary it will be perceived that the first fatal case of cholera occurred on the 30th of June and last case on the 30th of July, from this latter period to the 30th August there were twenty two cases of cholera and one case on the 17th Sept. none of which were fatal, and most of them were among convicts recently admitted into the prison.

The records of the penitentiary show the following alarming bill of mortality for the past year, namely—

Old age	1
Paralysus	2
Typhoid Fever	2
Cholera	116

The question often arises, what was the cause of the cholera in the penitentiary, and it is an inquiry the public has a right to make to the officers of one of it's institution. To this question can be given however, no very satisfactory answer.

There is, perhaps, no branch of medical science on which there exists more unsettled and indefinite doctrines, than on that of the etiology of epidemic disease, most of which are mere theries, the phantoms of the imagination baseless as dreamers vision, conjectural and vague.

When it is remembered, that the patient researches of the most learned, have for all ages, failed to discover the cause of an ague, no great astonishment need be excited, that the efficient cause of cholera, like that of other epidemics, is yet unknown, nor should there be any surprise

manifested that, in a brief report, like the present should decline the pursuit of the cause of a malady, of which at present, the effects are only known, for, while the general principles of prevention and cure are pretty well established among the most eminent and experienced of the profession, there, still exists so much discrepancy as to the cause of cholera, that it can scarcely be said that there is any authority upon the subject, none, at least, but such as is entirely hypothetical.

During the prevalence of this fatal scourge, genial skies overhung us, nature smiled around, and the earth presented no new phenomena, the same general cause which produced the disease in London and Paris, in the state of Maine and upon the Rio Grande, contributed to the same end within the walls of the Ohio Penitentiary.

In large cities, in camps and in crowded public institutions when the epidemic has once broken out, it prevails to a more alarming extent, than in districts thinly populated. This may be owing to the aggregation of a larger number of human beings and the consequent deterioration of the atmosphere. Be this as it may, after the cholera had prevailed here eight or ten days and the old hospital had been crowded with the sick and dying, not more than two or three either of citizens or prisoners, officers, or medical attendants excaped an attack especially those who had been occupied in this part of the prison.

The deleterious agent which produces epidemic diseases being present, the system must be in a condition susceptable to it's influence, before it will be developed, and the convicts, both morally and physically were precisely in such state, depressed by long confinement, exhaling most of their time, an unhealthy atmosphere, shut out, not only from the world, but from the contemplation of it's enjoyments, brooding over their misfortunes as well as the wrongs they had done to others, meditating in gloomy solitude the hopeless future with the dreaded pestilence clearly in view, and the almost certain prospect of sickness or death, and death too, within the walls of the penitentiary.

Many of the officers, medical attendants, and members of the family of the warden had been stricken with the disease, but nearly all had recovered, nor were they very liable to relapses, so fatal to the convicts, these were, happily, not surrounded by the same depressing influences, no massive walls obstructed their view, nor were the creaking hinges of the clanking prison doors forever ringing in their ears, nor were they compelled to look through iron gates to see the light of heaven, but the reverse, kind parents, mothers, sisters, wives and the sympathies of neighbors contributed their thousand affectionate offices to soothe and comfort them, and hope in the future, sustained and buoyed them up.

Altho the cholera was not very choice in the selection of it's victims, the strong and vigorous were more likely to recover, than the feeble or sickly, and the cool philosophic and determined, were less liable to attack, and more successfully treated, than the timid and irresolute.

As nearly as practicable, after taking charge of the hospital, I adopted the plan of keeping daily reports of the sick and invalids for the inspection of the officers and such other as take an interest in the health of the institution. I herewith, submit, in as compact a form as practicable, these reports, commencing from the 1st August last.

Those in the column designated, "in hospital" embrace such as required bed and remained both day and night.

Those designated as "out of the hospital," embrace such as come to the hospital to be prescribed for, but returned to their cells at night, and in some instances perform some light services, including also, convalescents who still require some medical attendance.

As a source of valuable statistical information, connected with the health of the prisoners I also present you with a diary of the weather, for the last three months, as perfect as the means within my reach would allow.

Respectfully submitted,

William Trevitt, M. D.,
Physician to the Ohio Penitentiary.

First Attempts to Resuscitate Acutely Arrested Heart

More than fifty years have now passed since the first attempts were made to resuscitate the acutely arrested heart by artificially maintaining the circulation in the hope that spontaneous cardiac output could be reestablished. Iglesrud, in 1901, and Starling and Lane, in 1902, were first able to report success with such a method.

The possibility of successfully reviving a patient whose heart action suddenly ceased has attracted the imagination of physicians for several centuries. With the advent of anesthesia and the report of the first case of cardiac arrest under anesthesia shortly to follow, in 1848, however, the urgency of preventing, or of treating, sudden failure of the cardiac conduction mechanism became more apparent.

With the advent of thoracic surgery and more recently cardiovascular surgery, a better knowledge of the pharmacology of the heart and an increasing understanding of the conduction mechanisms of the heart, the tempo of activity surrounding cardiac arrest and resuscitation has increased many fold.—Hugh E. Stephenson, Jr., M. D., Columbia, Mo.: *Missouri Medicine*, 51:370, May, 1954.

Fall Postgraduate Courses . . .

District Groups and Other Organizations Schedule Excellent Programs Throughout the State Giving Physicians Wonderful Choice of Subjects

EXCELLENT postgraduate programs are in store for Ohio physicians in various parts of the state this fall. Many of the programs scheduled are annual events and are well known to physicians in the area. Subject matter is varied and physicians will find an excellent choice of material.

Additional information on these and other programs will be published in subsequent issues of *The Journal.* Following are the programs announced before this issue went to press:

September 21-23—Ohio Academy of General Practice, Columbus.

September 29-30—Bunts Institute, Cleveland (also October and November programs).

October 1—Second Councilor District Meeting, Dayton.

October 6—Northwestern Ohio Medical Association, Tiffin.

October 13—Ashland County Medical Society Heart Program, Ashland.

October 22—Conference on Nutritional Aspects of Blood Formation, Cincinnati.

October 27—Sixth Councilor District, Akron.

* * *

Ohio Academy of General Practice Meets in Columbus Sept. 22-23

The Fourth Annual Scientific Assembly of the Ohio Academy of General Practice will be held on Wednesday and Thursday, September 22-23, in the Deshler-Hilton Hotel, Columbus.

The House of Delegates will convene on Tuesday, September 21.

Technical Exhibits by leading pharmaceutical, surgical instrument companies and other supply houses will be a part of the overall program.

A luncheon for the ladies has been arranged in the Ionian Room of the Deshler-Hilton for 12:30 p. m., Wednesday, with the Academy as host. Other entertainment features for the ladies is being arranged.

Registration booth will be open beginning at 8:00 a. m. on Wednesday, September 22, in the hotel Foyer. Hotel reservations should be made directly with the hotel of choice.

A cordial invitation is extended to all members and friends of the medical profession.

The scientific program has been announced as follows:

WEDNESDAY, SEPTEMBER 22

8:00 a. m.—Registration. **(All Time Is Eastern Standard)**

8:00—Visit Technical Exhibits.

9:00—Opening Annual Scientific Assembly.
Invocation.
Greetings from Ohio State Medical Association.
Greetings from Columbus Academy of Medicine.
Greetings from Franklin County Academy of General Practice.
Greetings from President, Ohio Academy of General Practice.

9:30—"Public Relations in General Practice," Dr. Richard C. Miller, Dayton.

10:00—"Medical Problems of the Athlete," Dr. John W. Wilce, Columbus.

10:30—Visit Technical Exhibits.

11:00—"Obstetrics in General Practice," Dr. Abe Kuhr, Dayton.

11:30—"Tuberculosis and the General Physician," Dr. I. Phillip Frohman, Washington, D. C.

12:00 noon—Lunch Period and Visit to Technical Exhibits.

1:30 p. m.—"The Patient with a Headache," Dr. Howard D. Fabing, Cincinnati.

2:00—"Poliomyelitis Immunization," Dr. S. R. Robbins, Cleveland.

2:30—"Multiple Sclerosis and Progressive Muscular Dystrophy," Dr. Dwight M. Palmer, Columbus.

3:00—Visit Technical Exhibits.

3:30—"Medical Education," Dr. Stanley C. Dorst, Cincinnati.

4:00—"The General Physician and the Hospital," Dr. Frank C. Sutton, Dayton.

4:30—Visit Technical Exhibits.

6:00—Social Hour and Banquet.
Toastmaster, Dr. A. R. Marsicano, Columbus.
"The Human Side of Medicine," Dr. Leo H. Bartemeier, Detroit.
Entertainment and Dancing.

THURSDAY, SEPTEMBER 23

8:00 a. m.—Visit Technical Exhibits. **(All Time Is Eastern Standard).**

9:00—"Newer Therapeutic Methods in Dermatology," Dr. Roy L. Kile, Cincinnati.

9:30—"Therapeutic Nuggets," Dr. Oscar F. Rosenow, Columbus.

10:00—"The Problem of Narcotic Enforcement," Mr. Ross B. Ellis, Detroit.

10:30—Visit Technical Exhibits.

11:00—"Hearing Impairment in Children," Dr. Charles E. Kinney, Cleveland.

11:30—"Cervical Disc, Shoulder, Arm, Hand

Syndrome," Dr. Winchell Craig, Mayo Clinic, Rochester, Minn.

12:00 noon—Adjournment.

* * *

Bunts Institute of Cleveland Offers Graduate Courses

The Frank E. Bunts Educational Institute, Cleveland Clinic, Cleveland, has announced three postgraduate courses to be held monthly beginning in September. The first of these courses is on the theme "Current Therapy in Pediatric Practice," and the second on "Diseases of the Chest." Details of the third will be announced later. The registration fee is $15 for each course, except for interns, residents and members of the Armed Forces in uniform, who will be admitted free.

CURRENT THERAPY IN PEDIATRIC PRACTICE WEDNESDAY, SEPTEMBER 29

Morning session beginning at 9:00 a.m.: Dr. R. D. Mercer, presiding; Opening Remarks, Dr. F. A. LeFevre; "Treatment of Congestive Heart Failure," Dr. W. L. Proudfit; "Treatment of Coma," Dr. Theodore Mortimer; "Treatment of Convulsions," Dr. E. M. Zucker; "Recognition of Poisoning," Irving Sunshine, Ph. D.; "Treatment of Complications of Steroid Therapy," Dr. J. R. Haserick; Intermission.

"Treatment of Tuberculosis," Dr. H. S. Van Ordstrand; "Diagnosis and Treatment of Adrenogenital Syndrome," Dr. Lawson Wilkins; "Roentgenologic Diagnosis of Adrenal Disease," Dr. E. F. Poutasse; "Respiratory Distress in the Newborn," Dr. Viola Startzman; "Treatment of Stridor," Dr. Samuel Spector; questions and answers; luncheon.

Afternoon Session, Dr. Viola Startzman, presiding; "Treatment of Purpura," Dr. J. S. Hewlett; "Treatment of Acquired and Congenital Hemolytic Anemias," Dr. J. D. Battle, Jr.; "Treatment of Sickle Cell Anemia," Dr. John Harris; "Treatment of Secondary Anemia, Dr. C. Q. McClelland; "New Roentgen Diagnostic Technics," Dr. A. S. Tucker; "Procedures in Evaluation of Intelligence," Miss Clare Robinson; Intermission.

Panel Discussion, "Constitutional Variations in Adolescence," Drs. Lawson Wilkins, E. P. Mccullagh and Samuel Spector; "The Year in Pediatrics," Dr. R. D. Mercer; question and answer period.

THURSDAY, SEPTEMBER 30

Morning session, Dr. Viola Startzman, presiding; "Hyperthyroidism," Dr. R. S. Dinsmore; "Surgery of Thyroglossal Duct Anomalies," Dr. George Crile, Jr.; "Maxilofacial Tumors in Children," Dr. H. E. Harris; "Recognition of Brain Tumors," Dr. W. J. Gardner; "Cardiac Arrest," Dr. C. E. Wasmuth; Intermission.

"Dysplasia of the Hip," Dr. R. D. Mercer; "Fulminating Ulcerative Colitis," R. B. Turnbull, Jr.; "Abdominal Neoplasms in Infants and Children," Dr. R. M. Wansbrough; question and answer period; luncheon.

Afternoon session, Dr. R. D. Mercer, presiding, "Treatment of Esophageal Stenosis," Dr. L. K. Groves; "Treatment of Diaphragmatic Anomalies," Dr. D. B. Effler; "Treatment of Small Intestinal Obstructions in Infants," Dr. E. W. Gerrish; "Surgery of the Biliary Tract in Children," Dr. S. O. Hoerr; "Surgical Treatment of Burns," Dr. Robin Anderson; "Trauma of the Eye," Dr. R. J. Kennedy; "Bone Tumors of Children," Dr. A. W. Humphries; "Roentgen Therapy of Malignancy," Dr. R. A. Hays; Intermission.

Panel Discussion, "Preoperative and Postoperative Care of Children," Drs. R. M. Wansbrough, D. E. Hale, Viola Startzman and Robin Anderson; question and answer period.

DISEASES OF THE CHEST

Sponsored by the Cleveland Society for Diseases of the Chest and the American College of Chest Physicians.

WEDNESDAY, OCTOBER 27

Morning session opens 9:00 a.m., Dr. H. S. Van Ordstrand, presiding; Opening Remarks, Dr. F. A. LeFevre; "Present Status of Antimicrobial Treatment," Dr. Harold Curtis; "Pathology as Affected by Antimicrobial Therapy," Dr. Thomas Kinney; "Surgical Trends in Tuberculosis," Dr. Harvey Mendelsohn; "Immunization with BCG," Dr. M. M. Perlich; "Trends in Tuberculosis Control," Dr. J. B. Stocklen; Intermission.

"Diagnosis and Antibiotic Therapy of the Pneumonias," Dr. Theodore Woodward; "Mucoviscidosis," Dr. R. D. Mercer; "Diagnosis Value of Kveim Test in Sarcoidosis," Dr. J. R. Haserick; Luncheon.

Afternoon session, 2:00 p.m.—Panel Discussion, "Emphysema," Dr. H. S. Van Ordstrand, moderator; Drs. George Wright, R. N. Westcott, and David Gillespie; Intermission; Panel Discussion, "Pneumoconiosis," Dr. Raymond McKay, moderator; Drs. Sidney Wolpaw, H. S. Van Ordstrand and George Wright.

THURSDAY, OCTOBER 28

Morning Session beginning at 9:00 a.m., Dr. F. A. LeFevre, presiding; "Surgery of Septal Defects," Dr. Earl B. Kay; "Surgery of Congenital Heart Disease," Dr. D. B. Effler; "Experimental and Clinical Use of the Heart-Lung Apparatus," Dr. George Clowes; "Pericardial Biopsy," Dr. W. L. Proudfit; "Cardiac Arrest," Dr. C. E. Wasmuth; Intermission.

Panel Discussion, "Surgery in Mitral Stenosis," Dr. A. C. Ernstene, moderator; Drs. F. M. Sones,

Jr., Salvatore Sancetta and Henry Zimmerman; luncheon.

Afternoon Session, Dr. D. B. Effler, presiding; "Cytologic Studies in Lung Cancer," Dr. L. J. McCormack; "Diagnosis and Treatment of Bronchogenic Carcinoma," Dr. Walker Munz; "Management of Mediastinal Tumors," Dr. Fred Cross; Intermission.

"Coin Lesions," Dr. L. K. Groves; "Lung Biopsy in Diffuse Lung Lesions," Dr. H. S. Van Ordstrand; "Middle Lobe Syndrome," Dr. D. B. Effler.

* * *

Second District Physicians To Meet In Dayton, October 1

Physicians of the Second Councilor District will be guests of the Montgomery County Medical Society for the annual meeting on Friday, October 1 in Dayton. In addition to the scientific program, there will be a brief business session during which district officers will be elected.

The afternoon scientific program will begin at 1:30 p. m. in the Veterans Administration Center, Department of Physical Medicine and Rehabilitation, in Dayton.

The program will include a Clinical Demonstration on "Mobilization of the Severely Disabled Patient," under direction of Dr. Leo Rosenberg, chief of physical medicine and rehabilitation for the local V. A. Center. The demonstration will cover the hemiplegic and paraplegic patient from the standpoint of acute care and convalescence and rehabilitation.

An open discussion will follow, during which Dr. Herman J. Bearzy, director of the Department of Physical Medicine and Rehabilitation, Miami Valley Hospital, will act as chairman.

Dr. A. B. C. Knudson, chairman of physical medicine and rehabilitation for the Veterans Administration, Washington, D. C., will take part in the discussion.

A social hour will be held from 5:30 to 6:30 p. m. in the Biltmore Hotel, followed by a banquet. Principal speaker for this occasion will be Dr. Knudson.

A feature of the evening meeting will be the annual Founder's Day observance for the Montgomery County Medical Society. This will be the 105th anniversary of the founding in 1849.

Woman's Auxiliary members of the Second District will meet in the Van Cleve Hotel for a noon luncheon beginning at 12:30. Mrs. Lottie Stobal Dettmar, nationally known monologuist of Chicago, will entertain. The ladies will join their husbands at the Biltmore Hotel for the social hour, banquet and evening program.

Akron—*The Akron Beacon Journal* on March 28 devoted a two-page spread in its magazine section to the Doctors' Orchestra of Akron.

Northwestern Ohio Association To Meet October 6 in Tiffin

The 110th Scientific Assembly of the Northwestern Ohio Medical Association will be held in the Shawhan Hotel, Tiffin, on Wednesday, October 6. This organization is composed of physicians of the Third and Fourth Councilor Districts, but all interested physicians are invited to attend.

At the noon luncheon meeting organizational matters will be discussed by Dr. James R. Jarvis, Van Wert, Third District Councilor; Dr. Paul F. Orr, Perrysburg, Fourth District Councilor, and Mr. Charles S. Nelson, Columbus, Executive Secretary of the Ohio State Medical Association.

The scientific program will include the following speakers and subjects:

"The Management of Prolonged Labor," Dr. Frank Kaltrieder, University Hospital Department of Obstetrics, Baltimore, Md.

"The Planning of Antibacterial Management with a Consideration of Pitfalls," Dr. Paul S. Rhoads, Editor of *Archives of Internal Medicine*, Chicago.

"Management of Facial Fractures," Dr. Joseph Ewing, Akron.

"Emergency Care of Head Injuries," Dr. Laurence M. Weinberger, Akron.

* * *

To Discuss Nutritional Aspects of Blood Formation at U. C.

A symposium on the Nutritional Aspects of Blood Formation will be held at the University of Cincinnati on Friday, October 22. The symposium is being made possible by support from the National Vitamin Foundation.

The meeting will begin at 9:15 a. m. in the Auditorium of the College of Medicine and continue through 5:00 p. m.

All interested physicians and scientists are invited.

Following are features and speakers on the program:

MORNING SESSION

Chairman, Dr. Richard W. Vilter, associate professor of medicine, College of Medicine, University of Cincinnati.

Welcome—Dr. M. A. Blankenhorn.

"Iron Metabolism in Relation to Microcytic Hypochromic Anemia," Dr. Carl V. Moore, professor of medicine, Washington University School of Medicine, St. Louis.

"The Relationship of Copper, Cobalt and Trace Elements to Hematopoiesis," Dr. George E. Cartwright, associate professor of medicine, University of Utah School of Medicine, Salt Lake City.

"Some Metabolic Interrelationships of Folic Acid Vitamin B_{12} and Ascorbic Acid," J. N. Wil-

liams, Ph. D., associate professor of biochemistry, University of Wisconsin.

"Interrelationship of Folic Acid, Vitamin B_{12} and Ascorbic Acid in Patients with Megaloblastic Anemia," Dr. John F. Mueller, assistant professor of medicine, and Dr. John J. Will, assistant professor of medicine, College of Medicine, University of Cincinnati.

AFTERNOON SESSION

Chairman, Dr. M. A. Blankenhorn, professor of medicine, University of Cincinnati, and director of the Department of Internal Medicine, Cincinnati General Hospital.

"The Absorption and Utilization of Vitamin B_{12}," Dr. Robert F. Schilling, assistant professor of medicine, University of Wisconsin School of Medicine.

"Relationships of Hormones to the Utilization of Essential Nutrients in Erythropoiesis," Roger C. Crafts, Ph. D., professor and chairman, Department of Anatomy, College of Medicine, University of Cincinnati.

"Antimetabolites and Antibiotics as Tools for Research on Blood Formation," Tom H. Jukes, Ph. D., Lederle Laboratories, Pearl River, N. Y.

"Stercobilin and Hematopoiesis," Dr. G. Watson James, III, associate professor of medicine, Medical College of Virginia.

"Essential Nutrients in the Management of Hematopoietic Disorders of Human Beings—A Resume," Dr. Richard W. Vilter.

* * *

Ashland County Sponsors Program On Heart, October 13

The Ashland County Medical Society and the Ashland County Heart Association announce "A Program for the Family Doctor and Diseases of the Heart" on Wednesday, October 13, from 2 to 5 p. m. at the Miller Memorial Building in Ashland.

Speakers and subjects will include: Dr. Maurice A. Schnitker, Toledo, "Congenital Heart Disease"; Dr. Wiley A. Forman, Columbus, "Rheumatic Fever"; Dr. William A. Proudfit, Cleveland, "Arteriosclerotic Heart Disease"; Dr. J. J. Conn, Columbus, "Hypertension"; Dr. Bernard A. Brofman, Cleveland, "Evaluation of Patient for Cardiac Surgery" and Dr. David Leighninger, Cleveland, "Cardiac Resuscitation."

All physicians are invited, especially those in adjoining counties. There are no charges or registration fees.

The Program Committee is composed of Drs. A. D. Robertson, C. B. Meuser and Wayne C. Smith.

Pemberville—Dr. Harley E. Ward who has practiced medicine for 52 years, was honored at a banquet arranged by the Pemberville Civic Club, and was presented a plaque.

Arthritis and Rheumatism Program in Cleveland on November 10

On Wednesday, November 10, the Cleveland Chapter of the Arthritis and Rheumatism Foundation and the regional members of the American Rheumatism Association are sponsoring a conference devoted to the rheumatic diseases. The meeting will be held at the Hotel Carter, in Cleveland, with a program from 9 a. m. to 5 p. m.

The scientific program will be followed by a banquet to which lay members of the Arthritis and Rheumatism Foundation are invited. The registration fee will be $10. All interested physicians are invited. Additional information may be obtained from Dr. William S. Clark, program chairman, 2073 Abington Road, Cleveland 6.

Scheduled speakers and their topics are as follows:

"The Diagnosis of Rheumatic Fever," Dr. T. Duckett Jones, New York City.

"The Prevention and Treatment of Rheumatic Fever," Dr. Charles H. Rammelkamp, Cleveland.

"The Diagnosis and Treatment of Gout," Dr. Alexander B. Gutman, New York City.

"The Diagnosis of Rheumatoid Arthritis," Dr. Charles L. Short, Boston, Mass.

"The Treatment of Rheumatoid Arthritis," Dr. William D. Robinson, Ann Arbor, Mich.

"The Nature and Treatment of Osteoarthritis," Dr. Walton Solomon, Cleveland.

"Rehabilitation of the Arthritic," Dr. H. Worley Kendell, Peoria, Ill.

* * *

Sixth District Meeting To Be Held in Akron October 27

The annual fall meeting of the Sixth Councilor District will be held in the Mayflower Hotel, Akron, on Wednesday, October 27.

An excellent program was being arranged as this issue went to press with scheduled lectures, discussion periods and panels on surgery, general medicine and obstetrics and gynecology.

Registration begins at 8:00 a. m. with a tour of the exhibits immediately following. The first scientific program begins at 9:30 a. m. and continues through the morning and afternoon with time out for luncheon.

A dinner at 6:30 p. m. with a speaker following will be part of the program.

Some Akron specialty societies and groups are making preparation to entertain physicians of the District in their respective fields.

Speakers and subjects are:

Louis M. Hellman, M. D., State University of New York, "Obstetrical Problems."

Clarence H. Heyman, M. D., Western Reserve University, "Congenital Osseous Deformities."

Charles E. Hendriks, M. D., Western Reserve University, "Cancer of Ovary."

Sylvester J. O'Connor, M. D., University of

Michigan, "Conservative Management of Acute Shoulder Syndromes."

Reed M. Nesbitt, M. D., University of Michigan, "Bladder Obstructions of Childhood."

Francis C. Grant, M. D., University of Pennsylvania, and **Gilbert Horrax,** M. D., Lahey Clinic, Boston, "The Neurosurgeon and the Herniated Disc."

William D. Robinson, M. D., University of Michigan, **L. Maxwell Lockie,** M. D., University of Buffalo, and **Bernard H. Norcross,** M. D., Buffalo General Hospital, "Rheumatic Diseases."

George Crile, Jr., M. D., Cleveland Clinic, "The Surgery of Peptic Ulcer."

The following panel discussions and conferences will be presented:

"The Control of Pain," Drs. Grant and Horrax.

"Thyroid Diseases," Robert M. Zollinger, M. D., Ohio State University, moderator; Marion A. Blankenhorn, M. D., University of Cincinnati; George Crile, Jr., M. D., Cleveland Clinic; Hymer L. Friedell, M. D., Western Reserve University; Harry Goldblatt, M. D., Mt. Sinai Hospital, Cleveland.

"Clinico-Pathology Conference," Drs. Goldblatt and Zollinger.

Problems Common to Arthritis and Orthopedics," Dr. Robinson, moderator; Drs. Heyman, Lockie, Norcross and O'Connor.

"The Ischemic Kidney," Dr. Nesbitt, moderator; Drs. Blankenhorn and Goldblatt.

"Case Presentation," Dr. Zollinger, moderator; Drs. Grant, Hellman, Heyman and Nesbitt.

"Hemolytic Anemias" (lecture and panel). Warren E. Wheeler, M. D., Ohio State University, **"RH Factor"**; Robert D. Mercer, M. D., Cleveland Clinic, **"Acquired Hemolytic Anemias"**; Wolfe W. Zuelzer, M. D., Wayne University, **"Spherocytosis."**

Rheumatic Fever "Is Being Prevented" In Youngstown Area Experiment

The American Heart Association in its recent bulletin reaffirms its previous prediction that rheumatic fever can be prevented by stating that rheumatic fever "is being prevented." The experience cited is from extensive programs that have been going on in the Youngstown area of Ohio and bordering areas of Pennsylvania in early treatment of "strep" infections among school children.

Specifically the bulletin points to records from Mercer County (Pa.) (to May, 1954), as follows: Throat cultures taken of children with sore throat or other symptoms, 240; negative for "strep," 195; positive for "strep," 45; new cases of rheumatic fever among children who had throat cultures taken, none.

At least three per cent of untreated "strep" infections, the Heart Association estimates, are followed by rheumatic fever.

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since July 9, 1954. The list shows the county in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

BUTLER COUNTY
Eugene R. Turner, Middletown

CLERMONT COUNTY
Richard D. Carr, Williamsburg
Donald K. Ebersold, Milford

COLUMBIANA COUNTY
William A. Kolozsi, Salem
Kenneth W. Turner, East Liverpool

GREENE COUNTY
Robert F. Swanson, Fairborn

HAMILTON COUNTY
Paul A. Busam, Cincinnati
Edmund O. Casey, Cincinnati
William R. Culbertson, Jr., Cincinnati
Arthur S. Doyle, Cincinnati
Donald J. Frank, Cincinnati
Charles N. Manley, Cincinnati
James R. Merkel, Cincinnati
Howard E. Rissover, Norwood
Leonidas Romanowski, Cincinnati
Claudia R. Simon, Wyoming
Norman L. Straw, Cincinnati
Roland G. Wintzinger, Cincinnati

HANCOCK COUNTY
Joseph G. Barkey, Findlay

HARDIN COUNTY
Robert B. Elliott, Ada

LUCAS COUNTY
Henry McWhorter, Toledo
Willis J. Wendler, Jr., Toledo
Harry C. Zaenger, Toledo

MAHONING COUNTY
Frederic R. D'Amato, Youngstown
Frank W. Morrison, Youngstown

MARION COUNTY
Isaac E. Michael, Marion
Thomas N. Quilter, Marion

MEDINA COUNTY
Karl F. Burns, Jr., Sharon Center

MONTGOMERY COUNTY
Gerard C. Geswein, Dayton
Norbert L. Kosater, Dayton

ROSS COUNTY
William J. Corzine, Jr., Chillicothe

SCIOTO COUNTY
Charles E. Cole, Portsmouth

STARK COUNTY
John F. Thompson, Canton

General Practitioners Are Invited To Participate in Pittsburgh Course

General practitioners of Ohio, especially those in the eastern counties of the State, are invited to participate in a series of postgraduate courses being offered at the Montefiore Hospital, Pittsburgh, Pa., under sponsorship of the Medical Society of the State of Pennsylvania.

The course will be given 15 consecutive Thursdays, starting September 9, 9:30 a. m. to 4:00 p. m. Registration fee is $50. The course is approved for credit by the American Academy of General Practice.

The Postgraduate Hospital Training Course will return to the preceptor-type of bedside teaching. Enrolees will be divided into three sections. Section A will be originally assigned to medicine, Section B to surgery, and Section C to the specialties. At the end of five weeks all groups will rotate.

Course director is Dr. Leo. H. Criep. Applications or inquiries should be addressed to: Commission on Graduate Education, 230 State Street, Harrisburg, Pa.

Rural Medical Scholarship . . .

Association Is Now Aiding Its Sixth Student from Rural Area In Medical School as Millersburg Youth Is Selected by Committee

WINNER of the sixth annual Ohio State Medical Association Rural Medical Scholarship is M. Robert Huston, 22-year-old Millersburg youth who will receive $2,000 toward his four-year medical course. He is the son of Mr. and Mrs. Lewis C. Huston of the Holmes County town.

Deciding factors in his selection, in addition to an excellent scholastic record, were testimonials by Millersburg organizations and individuals who praised him for his community activities and leadership. He was active back home in the 4-H Club, Scouting and the youth work of his local Methodist Church. In addition, he was able to earn about half of his premedical college expenses.



ROBERT HUSTON

Huston received his premedical training at Ohio Wesleyan University, where in 1953 he was awarded the Edward L. Rice Zoology Scholarship for special studies in that field. He will enter the University of Cincinnati College of Medicine this fall.

The medical scholarship plan was instituted five years ago by the Ohio State Medical Association to stimulate the interest of rural young men and women in the study of medicine and to encourage them to become country doctors. An Ohio student from a rural community who will enter his freshman year in a medical college is selected each year and receives $500 each year for the four-year course as long as he remains in good standing.

The scholarship is administered by the Association's Committee on Rural Health which is composed of the following persons: Dr. Edmond K. Yantes, Wilmington, chairman; Drs. L. E. Anderson, Greentown; Byron B. Blank, DeGraff; E. G. Caskey, Mineral Ridge; Jonathan Forman, Worthington; V. R. Frederick, Urbana; Carl F. Goll, Steubenville; L. W. High, Millersburg; H. R. Mayberry, Bryan; Carll S. Mundy, Toledo; W. L. Murphy, Cardington; J. I. Rhiel, Port Clinton; James M. Snider, Marysville; G. N. Spears, Ironton; H. K. Van Buren, Carey; D. S. Williams, Marietta; and Kenneth Taylor, Pickerington. Mr. Hart F. Page, assistant public relations director of the State Association, is secretary of the committee.

PREVIOUS SCHOLARSHIPS

Previous recipients of the scholarships are:

Dr. C. Craig Wright, formerly of Winterset, Guernsey County, who received his M. D. degree from Ohio State in 1953, took his internship and is now serving as a medical officer with the U. S. Air Force;

Dr. Robert G. Smith, who came from Proctorville, Lawrence County, and has returned there with his family to reside, received his M. D. degree from Ohio State this year and is taking an internship at St. Mary's Hospital in Huntington, W. Va.;

Donald Nikolaus, Johnsville, Morrow County,



To select one scholarship winner from the group of applicants took several meetings of the Judging Committee shown above as members met in Columbus. Left to right, are: Mr. Page, Drs. High, Mayberry, Yantes, Taylor and Frederick. Dr. Forman, not shown above, also was present as a member of the Judging Committee.

who will begin his senior year at Ohio State this fall;

J. Daniel Timmons, New Madison, Darke County, now going into his junior year at O. S. U., and

Raymond M. Cole, Findlay, who will enter his sophomore year at the University of Cincinnati College of Medicine this fall.

The scholarship is one of the Association's practical answers to the question, "What are Ohio doctors doing about the shortage of rural practitioners?" Another Association-sponsored project is the Physician Placement Bureau operated through the Columbus Headquarters Office which acts as liaison between physicians seeking locations and Ohio communities in need of physicians. Still another is the Series of Orientation Courses for Senior Medical Students in which the advantages of a rural practice are discussed frankly by physicians who have had practical experience in rural areas.

"DOCTORS AND POLITICS"

OCCASIONALLY one hears a physician, or someone else, say: "Doctors should keep out of politics." I heartily disagree.

By way of explanation, let me say that I believe physicians should not become a regimented part of partisan politics. Moreover, medical societies should not engage in political activities, even if they were permitted by law to do so, which they are not.

On the other hand, I believe it is the duty of each physician, as a citizen, taxpayer, and civic-minded individual interested in the welfare of his home community, state and the nation, to become actively, personally interested in politics. Namely, he should become interested in supporting and helping to elect well-qualified persons to various public offices.

If you agree, you will have a chance to demonstrate your interest between now and Tuesday, November 2, the day of the General Election in Ohio.

Here are a few suggestions for action on your part:

1. Get all the information you can about the qualifications and views of the candidates. The officers and legislative committee of your own local medical society have been requested to gather such data and to make them available to you and other members.

2. After analyzing the information referred to, decide to actively support a candidate for each office whom you believe to be qualified and worthy of public trust.

3. Support the candidates you decide upon by making a financial contribution, if possible, to his campaign activities; distribute his campaign literature; boost his candidacy among your friends, neighbors and voting members of your family.

4. Make sure you, members of your family and your friends are qualified to vote on November 2. If not, see your local Board of Elections.

5. Be sure to vote on November 2. Join with others in getting voters who favor your candidates to the polls on election day. Assist in programs to make it possible for the sick and shut-ins to get to the polls.

If what I have suggested is "politics," sobeit. Those who comply will, I know, be fulfilling one of the basic requirements of good citizenship.

M. D. Prugh, M.D.,
President.

Doctor-Draft Registrants . . .

Selective Service Issues New Procedure for Handling Regular and Special Registrants; Hershey Warns Against Continued Deferments

NATIONAL Selective Service Headquarters has issued a new procedure for handling of doctor-draft registrants who also are subject to the regular Selective Service law.

The bulletin issued on this (Operations Bulletin No. 88) by General Hershey of National Selective Service also again warns against continued draft deferment of hospital registrants unless they are critically needed.

Following is the text of Operations Bulletin No. 88 pertaining to the classification and induction of both regular and special doctor-registrants:

* * *

SUBJECT: Classification of Persons Who Are Both Regular and Special Registrants.

1. Persons who have registered under the provisions of section 3 of the Universal Military Training and Service Act, as amended, are referred to in this bulletin as "regular registrants."

2. The need for physicians and dentists by the Armed Forces should be supplied to the fullest extent possible by processing regular registrants for induction. Such registrants shall be processed and ordered for induction as regular registrants without regard to their priority status as special registrants.

In the case of any such regular registrant who has been ordered for induction and has made every effort to secure a commission and **enter on active duty**, the State Director of Selective Service has authority under section 1632.2 of the Selective Service Regulations to postpone the registrant's induction for the time necessary for him to secure a commission and **enter on active duty**.

At the time the registrant is ordered for induction he shall be notified that the State Director may postpone his induction in order to permit him to secure a commission and **enter on active duty** if he furnishes his local board, prior to the date of induction, with evidence that he has applied for a commission and **active duty**. The registrant should also be informed that if he is not commissioned and **on active duty** due to any delay or failure on his part that he will be required to report for induction.

3. A regular registrant who is also a special registrant has a dual liability for service under the law. Each such registrant shall be classified both as a regular registrant and as a special registrant, except that no special registrant who is in the fourth priority or who is a veterinarian in the third priority shall be classified as a special registrant until further instructions are issued by this Headquarters.

4. Local boards should continue to give serious consideration to the deferment of a regular registrant or a special registrant who holds a degree in either medicine or dentistry in order that he may complete up to one year of internship. Such a registrant should be placed in Class II-A for the purpose of completing a residency only if in the opinion of the local board his services are absolutely essential to the operation of the hospital and should not be so classified merely because of the desire of the hospital or the registrant that he complete a residency.

5. The National Advisory Committee on the Selection of Physicians, Dentists, and Allied Specialists has urged that particular attention be given to those registrants who were deferred as hospital interns or residents during the hospital year ending June 30, 1954. Over the past year, the Committee has repeatedly urged hospitals not to appoint to their staffs for the hospital year beginning July 1, 1954, any physicians who have obligations for military service as regular registrants or as special registrants in Priority I or Priority II or in Priority III born after August 30, 1922.

The Committee has also urged State and local advisory committees not to support the deferment of such individuals. The survey of hospital house staffs conducted by the Committee indicates that during the hospital year ending June 30, 1954, there were in the hospitals of this country approximately 1,300 interns and more than 1,000 residents who are in Priority III and under 32 years of age. This number will be required to fill the indicated needs of the Armed Forces during the year ending June 30, 1955.

Lewis B. Hershey,
Director.

Roster of Speakers on Heart Subjects Is Offered

The Speakers Bureau of the Ohio State Heart Association has issued a booklet entitled *A Program on Heart Disease*, which includes the names of physicians in Ohio willing to talk on various phases of heart disease before medical groups. These are being distributed to County Medical Societies, Health Departments and similar groups. A copy may be secured by writing Ohio State Heart Association, 55 East State Street, Columbus 15, Ohio.

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

N. E. P. H. WARRANTS ACTIVE SUPPORT OF ALL PHYSICIANS

National Employ the Physically Handicapped Week will be observed in Ohio, October 2 through October 9. Every physician in Ohio should realize that as a physician and as a citizen he has a vital interest in the problem of the handicapped. Each should give his fullest cooperation in making the observance of this week a success.

The Medical Advisory Sub-Committee of Governor Lausche's Committee on Employment of the Physically Handicapped has recommended the following objectives not only for observance of this special week but, also, for a year-round attack on the problem:

1. To educate all physicians concerning the medical aspects of employment of the handicapped.
2. To educate the employers concerning the abilities of handicapped people.
3. To stress the relationship between physical examination and the physical demands of a particular job to create an understanding of physical standards for various jobs.
4. To help physicians work with handicapped people in such a way as to encourage proper attitudes toward their handicaps.
5. To stress with physicians and others the importance of early return to work handicapped individuals.
6. To try to make available to employers detailed physical capacity information with regard to particular jobs in order that proper placement of handicapped individuals may be made.
7. To channel information of the problems of the handicapped to the medical profession through various medical publications.

In a recent communication to *The Journal*, Dr. Herman J. Bearzy, Dayton, specialist in physical medicine and rehabilitation and chairman of the Governor's Medical Advisory Sub-Committee, made these pertinent comments and suggestions on this subject:

"We must strengthen N. E. P. H. due to the fact that two million disabled persons, who could be rehabilitated and thus returned to productive work, are being denied this due to lack of funds through rehabilitation centers. This is a horrible waste of human energy. If we had funds the problem would be relatively simple how to prepare and employ more and more of the handicapped. How to train and employ the 88 per cent disabled through illness, 5 per cent injured in work accidents, 5 per cent through other accidents and 2 per cent handicapped at birth; these people and those who will join them today, tomorrow and the next day are the problem. If we could somehow rehabilitate into gainful employment overnight the 2,000,000 men and women not now able to work because of disability, we would add to our Nation's productive force some four billion man hours per year. This staggering total is almost equal to the number of man hours now worked by Federal employees each year.

"One of the key factors in the guidance and placement of the physically handicapped is an accurate assessment of physical capacities. The ease or difficulty in making such an appraisal varies not only with the nature of the disability but the degree to which the individual has been able to make adjustments and compensations. Perhaps the most practical way of making the determination is to give the handicapped individual a 'performance' or 'achievement' test for demonstrating his physical capabilities. One can ascertain whether or not the individual is able to walk, or to climb stairs, or to use his hands and his fingers. But prior to actual job tryout, an estimate should be made to whether he can perform these activities in a job situation; that is, in a particular work environment and for 2, 3, or 4 hours, or all day long as the job may require."

NO APOLOGY NECESSARY; IT WAS A BAD BILL

After the House of Representatives of the U. S. Congress shelved President Eisenhower's proposed bill for reinsurance of voluntary prepaid health plans, rather caustic attacks, blaming the American Medical Association and various state and local medical societies, were launched by some politicians and certain newspapers. Even the President lost his temper when discussing the situation in a press conference. He indicated he would continue to fight for the proposal.

In our opinion, we don't have to apologize to anyone for having opposed the proposed Federal reinsurance measure. Most of the nation's insurance experts also opposed it. The opposing groups came to these salient conclusions: The bill, as considered by Congress, would add nothing to the present rapidly expanding and successful voluntary health insurance field; would inevitably result in federal subsidization of the private insurance industry; would not make health insurance more attractive to persons who can afford to purchase it; would not make health insurance available to the indigent unless the government provides a subsidy; would not reduce the cost of insurance unless sound underwriting is disregarded—a dangerous step; would give extensive insurance regulatory power to a federal agency without convincing need that such regulatory power is necessary.

Apparently most of Ohio's Congressmen concurred in the views of Ohio physicians. The only ones who voted against the motion to send

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Infant Food





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Nursing and expectant mothers allergic to animal milk find SOYALAC a most nutritive beverage. It can be used freely in milk-free diets.

Free Booklet! *Further information on SOYALAC Infant Food is available from Loma Linda Food Company, Arlington, California, or Mount Vernon, Ohio.*

the bill back to committee (to shelve it) were the following, and even some of them may have been prepared to vote against the measure had it come to an out-and-out vote on the floor or if they were not reluctant to vote against the desires of the President: Ayres (Akron), Mrs. Bolton, (Lyndhurst), Oliver P. Bolton, (Mentor), Schenck, (Dayton) and Secrest (Senecaville).

It is quite obvious that the issue is not dead. Some have said that defeat of the Eisenhower bill will hasten the passage of a drastic compulsory health insurance program such as the old Truman proposal.

We doubt that, unless the personnel of Congress changes a great deal. Certainly the great majority of present Congressmen who voted against the reinsurance bill are not going to support anything like the old Truman measure and many of those who gave the Eisenhower bill a pat on the back are against anything as dangerous as the old Truman plan.

Of course, if there is a radical turnover in Congress at the November 2 elections, anything can happen. Members of the medical profession, and others who don't want the Federal Government messing into the medical insurance field, should bear this in mind as General Election Day approaches.

QUESTION OF AN ASSISTANT'S FEE

Writing on "Fees" in the Montgomery County Medical Society Bulletin, Dr. Richard C. Miller, president of the society, offers the following sound and timely advice and suggestions regarding assistant's fees:

"The question of an assistant's fee in surgery is the cause of much unrest among patients. When a referring physician sends a patient for consultation with the possibility of surgery in mind, the consulting surgeon then has an obligation to the referring doctor. If surgery is decided upon the tactful surgeon will tell the patient that he will need an assistant to help him which should be the referring doctor. This paves the way for the assistant to charge a fee for his services and also take part in the after-care of the patient. In my experience a lump fee to cover assisting at the operation and seeing the patient through his hospital stay has proved the best. Here again it is best to have the patient know that the referring doctor will charge a fee, and this can be discussed in advance, just as the consulting surgeon will tell the patient what his fee will be. This saves dissatisfaction at a later date. Besides, it's very good PR."

As Dr. Miller's terse suggestions infer, resolutions, red tape and regulations are not necessary to meet this situation. The right attitude on the part of the surgeon and willingness to explain matters to the patient will just about fill the bill.

DEATH CLAIMS FORMER PHYSICIAN-LEGISLATOR

The many friends of Dr. H. T. Phillips, both within and outside the medical profession, will regret to learn that he died recently at his home in Athens, Ohio. Dr. Phillips served for a number of terms in the Ohio House of Representatives and several terms in the Ohio Senate. While serving in the Ohio General Assembly, he rendered many valuable services to the medical profession through consultation on legislative matters and by firm action in support of sound principles and policies on medical and health questions. Dr. Phillips authored a number of bills on important medical and health subjects which were enacted and are now on the statute books. To his family, the medical profession of Ohio extends sincere sympathy.

LIST OF A. M. A. MEMBERS IN OHIO GROWING

At present, 87.5 per cent of the members of the Ohio State Medical Association are members of the American Medical Association. The figures are: 8,101 O. S. M. A. members; 7,095 A. M. A. members. Incidentally, by going over the seven thousand mark, Ohio will be entitled to an eighth A. M. A. delegate in 1955.

Ohio can even do better, in our opinion. Assuredly, there are a considerable number of O. S. M. A. members who are not on the A. M. A. roster, who should be. Medical affairs, activities and problems have long since ceased to be just local or state in scope. A strong national organization is a "must." In these days, the physician who says "to heck with the A. M. A." is simply refusing to face realities and helping to undermine his own welfare and interests. He'd better join up.

PRINT YOUR NAME UNDER SIGNATURE ON FEE BILLS

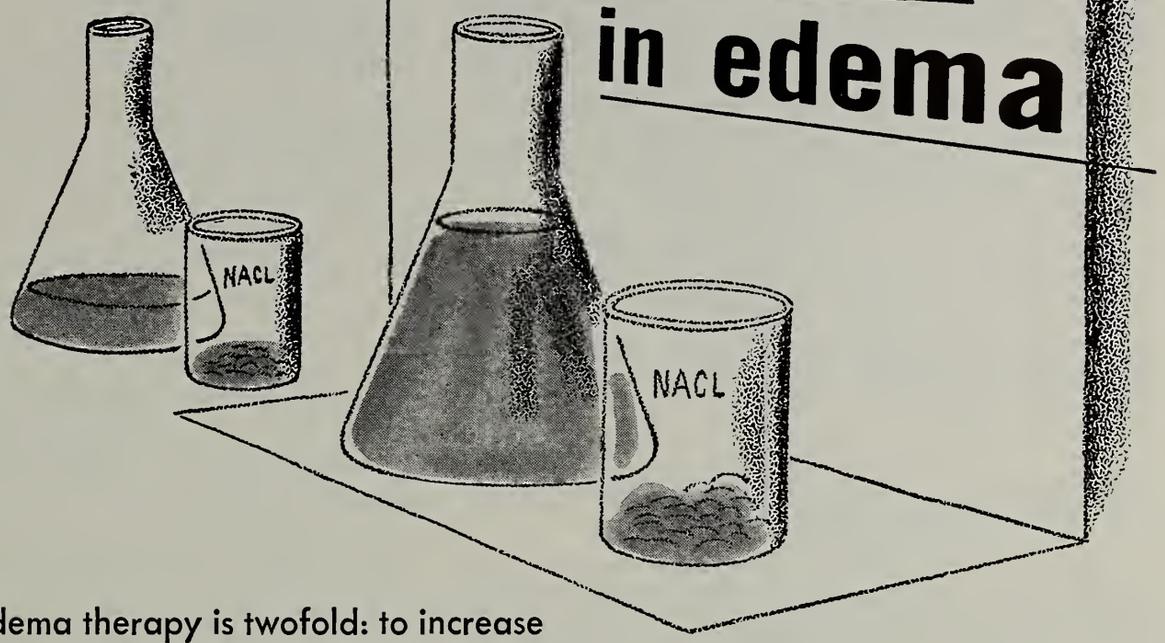
Some physicians who have rendered services to Workmen's Compensation claimants are not being paid, or are not being paid promptly, according to the Claims Section of the Ohio Industrial Commission, because of their poor penmanship. In other words, the Auditing Department can't make out the signatures signed to their fee bills submitted to the Commission.

A few cases might not create much of a problem. However, each month the Auditing Department has literally dozens of fee bills which have been approved but for which checks can't be drawn and mailed because the name of the physician can't be discerned from the signature.

Each physician can very easily aid the Commission and protect his own interests by doing one of two things:

1. Type or print name and address on the fee bill, over or under his signature, on all fee

increasing the excretion of water and sodium in edema



The aim of edema therapy is twofold: to increase the volume of fluid excreted from the body and, of equal importance, to effect a removal of water-binding sodium ions.

Salyrgan-Theophylline, established through the years as a dependable mercurial diuretic, performs both of these functions.

SUPPLIED:

Ampuls of 1 cc. and 2 cc. — boxes of 10, 25 and 100.

Tablets — bottles of 100, 500 and 1000.

SALYRGAN®-THEOPHYLLINE

Clinical response to Salyrgan-Theophylline is usually rapid. Within the first day after administration much of the excess tissue fluid is mobilized and eliminated. Up to 10 liters may be excreted in a twenty-four hour period. Similarly, excretion of 20 Gm. or more of sodium chloride within twenty-four hours after Salyrgan-Theophylline has been observed.[1,2]

For removal of edema and ascites in cardiac and cardiorenal diseases; nephrosis, and cirrhosis of the liver.

WINTHROP

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NEW YORK 18, N. Y. WINDSOR, ONT.

1. Nielsen, A. L., Bechgaard, P., and Bang, H. O.: Low-Salt Diet in Treatment of Congestive Heart Failure. *Brit. Med. Jour.*, 1:1349, June 16, 1951.

2. Brown, W. E., and Sutherland, C. G.: Control of Edema in Pregnancy. *GP*, 8:65, Nov., 1953.

Salyrgan, brand of mersalyl, trademark reg. U. S. Pat. Off.

bills, forms, reports, etc., filed with the Commission, or

2. Have a rubber stamp made up with his name and address, with a blank space for signature of physician. In partnerships or groups, the stamp can identify the partnership or group and a space provided for signature of the particular physician of the partnership or group who rendered the service and is responsible for the report. In such cases, the auditing department can make up one statement and warrant covering all bills received from members of the partnership or group during the past month.

Unless all physicians adopt one of these suggestions, some of them are not going to be paid. Lacking detectives and handwriting experts, the Commission has no alternative but to hold fee bills with unidentified signatures in a pending file until the physicians involved squawk and, in squawking, write their name and address in a legible manner.

NOTIFY NARCOTIC AUTHORITIES IF YOU CHANGE ADDRESS

Do you know that the Harrison Narcotic Act, under which a physician must pay a tax and register in order to lawfully prescribe, dispense and administer narcotics, requires a physician to notify the Collector of Internal Revenue of his district in event he changes his office address?

Unless this is done, within 30 days, the physician is subject to drastic penalties.

Better keep this in mind should you change your office address.

IMPROVED MEDICAL SERVICE SHOULD RESULT FROM NEW PHONE RULES

When the Public Utilities Commission of Ohio recently established minimum telephone service standards applying to all telephone companies doing business in Ohio, it set up rules requiring telephone companies to maintain service on a 24-hour basis; to handle calls without unreasonable delay; and to restore interrupted service within a period of two days, if at all possible.

This action should be of great assistance to physicians throughout the state in their efforts to supply prompt medical care to their patients. In many rural areas people are solely dependent on telephone service to contact their physicians. Compliance by telephone companies with the new regulations will make it possible for physicians to give more efficient and more prompt services, especially in emergencies and in cases of critical illness.

Also, the Commission adopted a regulation that operators shall maintain the secrecy of telephone conversations. This is in line with the principle of confidential communications applying to physician-patient relationship.

The Commission is to be commented for its action along these lines and the telephone companies merit equal commendation for having readily accepted the new standards, many of which will not take effect for a period of 12 months in order to give companies an opportunity to make substantial adjustments in facilities.

GIVE 'EM A CHANCE TO PROVE THEY'RE GOOD OR BAD

One of our good old American principles has been that a person is innocent until proven guilty. Application of it to two current issues would seem to be appropriate.

Potshots are being taken by some at the new mental hygiene setup in Ohio. Some say the law creating the new department is no good; others are criticizing its administration although the department has been in existence only since July 1.

There are some finding fault with the recently issued regulations establishing minimum standards for hospitals. Some say they are too restrictive or are incoherent; others contend they don't go far enough.

The chances are that neither of the targets for attack are perfect pieces of workmanship. Nevertheless, in our opinion, they deserve a reasonable time to either prove their worth or their weaknesses. In the end, if correct in theory, they always can be improved upon, administratively, by trial and error and the adoption of amendments. Let's give them a chance.

O. S. M. A. HAS NO INSURANCE COMPANY AGREEMENTS

The All-American Casualty Co. of Chicago has sent literature to certain Ohio physicians regarding a lifetime income disability policy. The leaflet has typed on it the words, "Ohio State Medical Association" and carries the statement that the company "has selected the membership of your association for its . . . plan," etc.

Obviously, the physician-reader gets the impression that there is some kind of an agreement between All-American Casualty and the Ohio State Medical Association.

The answer is: There isn't.

The Ohio State Medical Association has not entered into an agreement with any insurance company offering life, accident or health coverage for physicians. Moreover, it offers no endorsement of any company and its policies.

Some insurance companies offer insurance coverage which is designed especially for physicians and other professional people. That they have a perfect right to do. However, no company has the right to state, or infer, that its product has the endorsement of the Ohio State Medical Association or to even intimate that the Association has entered into any selling or solicitation agreement with it.

Income* for the members of the Ohio Medical Profession from the first day* of sickness or injury...

NOW! Not for only 26 weeks

— Not for only 52 weeks

but even for your entire lifetime

House Confinement not required at any time

Accidental loss of hands, feet or eyesight pays monthly benefits — not just a lump sum

TAX FREE DOLLARS — Disability insurance income is not taxable. For example, $3600 disability insurance income is equivalent to about $5000 regular income

EXTRA BENEFITS — Double monthly benefits while you are hospitalized payable for as long as three months

Cash benefits for accidental death

Double income benefits if disabled in specified travel accident named in the policy

OTHER IMPORTANT FEATURES — Waiver of Premium Provision • Commercial Air Line Passenger Coverage • No Automatic Termination Age

Covers most accidents from date of policy and most sickness originating more than 30 days after date of policy, excepting those incurred while in military service of any country at war, or resulting from war, any act of war, suicide, attempted suicide, insanity, mental disease, certain foreign travel, any pre-existing condition or any hazard of aviation other than commercial air line passenger travel



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Ohio's Mental Hospital Program . . .

American Psychiatric Association Makes Extensive Study of State's Institutions and Laws; Entire Mental Health Field To Be Surveyed

OHIO'S mental hospital program is basically sound but improvements are needed, according to a comprehensive study made by the American Psychiatric Association.

The study, begun in 1952 at the request of Judge J. H. Lamneck, then director of the Department of Public Welfare, cost the state $9950 including expenses. It was made by the American Psychiatric Association's central inspection board and carries the board's recommendations.

"The study confirms many of our own findings," Dr. John D. Porterfield, director of the new Department of Mental Hygiene and Correction, said upon making public the three volume work. The entire report covers more than 800 pages.

"I am sure we will find it of value and will be able to integrate many of its ideas into our programming," he added. "Some of the improvements recommended have already been made since the study was undertaken two years ago."

Dr. Porterfield said he had authorized the American Psychiatric Association to make an additional survey which will cover the entire field of mental health in Ohio. Work on this is scheduled to begin September 1 and will continue until about April 30, 1955.

OVERCROWDING CITED

The A. P. A. study finds that, in common with other states, overcrowding of present facilities is one problem to be overcome. The Cincinnati area is used as an example.

"This district has a population of approximately 945,000," says the report. "If the average number of hospitalized patients per thousand population (3.4) in the United States is applied to this figure, a theoretical hospital population in this district would be 3,749.

"If this rate were to be increased to five patients per thousand population as it is in some of the older states, the theoretical number of patients would be increased to 4,675, a number far beyond the present capacity of the hospital and greatly in excess of the desirable population of 1,500-2,000.

"The capacity of the Longview State Hospital, according to the standards of the American Psychiatric Association, is 1,803 beds and an excess of 1,453 patients already exists," the report noted.

The A. P. A. recommended, "in order to correct this situation new beds must be provided, either on the existing site or elsewhere. If more beds are added to the existing hospital, the small hospital idea must be sacrificed.

"The logical solution is to build a new hospital, modern in all respects, in the Cincinnati area. A like situation prevails in the Cleveland, Massillon, Toledo and Columbus districts. The same solution is recommended in each case."

Governor Frank J. Lausche recommended more mental hospital beds in Ohio at the Governors' Conference on Mental Hygiene last January in Detroit (See May issue, Page 478) and again at Cincinnati several months ago.

PLANS FOR BUILDING

Dr. Porterfield said the Division of Mental Hygiene hopes to build a 1,000 bed hospital in Hamilton County (Cincinnati) at an estimated cost of $7,315,000 and a 2,500 bed hospital in Richland County (Mansfield) at an estimated cost of $11,815,000 as well as expand the Hawthornden State Hospital (Macedonia, near Cleveland) by 800 beds at a cost of $2,500,000, if funds are made available by the Legislature.

The Richland County hospital would serve counties now handled by both Apple Creek (Wooster) and Tiffin state hospitals plus part of the Toledo State Hospital area. This would allow existing facilities at Apple Creek and Tiffin to be used by the mental deficiency program.

Dr. Porterfield noted that at Longview a 125 bed building was completed recently and the department is ready to advertise for bids on another building of the same size. At Massillon State Hospital a 143 bed building is under contract but construction has been delayed by an area strike.

The American Psychiatric Association study found that Ohio's mental hospitals have the same major personnel problem as other hospitals: an acute shortage of registered nurses.

Because of this, the ratio of nurses to patients is far below the A. P. A. standard. If nurses were available, it would cost a minimum of $5,000,000 a year to meet the standard.

Dr. Porterfield pointed out that mental hospitals find it more difficult to obtain nurses than other hospitals because of the nature of the work.

RATIO OF ATTENDANTS

The study revealed, however, that the ratio of total attendants to patients in Ohio mental hospitals much more nearly approaches the A. P. A. standard.

The A. P. A. study recommended that "all functions usually associated with a state mental

for greater safety in streptomycin therapy...

DISTRYCIN

Squibb Streptoduocin
Streptomycin and dihydrostreptomycin in equal parts

Distrycin has an important advantage over streptomycin. It has the same therapeutic effect but ototoxicity is greatly delayed. Since the patient is given only half as much of each form of streptomycin as he would have on a comparable regimen of either one prescribed separately, the danger of vestibular damage (from streptomycin) or cochlear damage (from dihydrostreptomycin) is significantly lessened.

Signs of vestibular damage appear in cats treated with Distrycin as much as 100 per cent later than in animals given the same amount of streptomycin.



Cat treated with streptomycin shows no nystagmus after whirling.



Cat given the same amount of Distrycin has normal reflex.

On dosage of 1 Gm. per day for 120 days, ototoxicity was as follows*:

	Vestibular damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	12	6	18
Dihydrostreptomycin	6	0	6
Distrycin	0	0	0

	Cochlear damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	0	0	0
Dihydrostreptomycin	12	3	15
Distrycin	0	0	0

**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

Distrycin dosage is the same as for streptomycin. In tuberculosis the routine dose is 1 Gm. twice weekly, in conjunction with daily para-aminosalicylic acid or Nydrazid (isoniazid). In the more serious forms of tuberculosis, Distrycin may be given daily, at least until the infection has been brought under control.

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health program should be removed from other departments and reorganized in a new Department of Mental Health."

The recent creation of the Department of Mental Hygiene and Correction by removing all mental, penal and correctional institutions from the Department of Public Welfare was a step in this direction.

The study recommended a number of changes in the laws pertaining to commitments and discharges. These included placing a twelve month time limit on trial visits, as "patients who have adjusted satisfactorily for a period of twelve months should be automatically discharged."

PERSONNEL POLICIES

Also called for was some revamping of personnel policies. Among the recommended changes was establishment of a new unit to administer maintenance charges on a cash basis. Employes would pay stated prices for their meals and accommodations instead of a blanket monthly deduction from their wages.

"Many employes' complaints and other unsatisfactory practices would be eliminated by the establishment of such a department," the study said. "There would be no question of employes' food being taken from the food allowance for patients.

"Employes would pay for the food eaten only and would therefore not be concerned about the meals they did not eat at the hospital. Waste would be reduced and costs would not be a controversial matter."

Dr. Porterfield pointed out, however, that a change to such an arrangement might in effect result in a pay cut for employes at a time when it is difficult to get them because of unfavorable salary schedules.

"The present deductions are extremely low," said Dr. Porterfield, "and even if we could do as well on a cash basis, the extra cost of administration would have to be reflected in the prices."

After issuing the foregoing comments, Dr. Porterfield announced on August 3 that he had set up a committee to study this particular phase of the recommendations.

The survey recommended that restraint and seclusion of patients "be confined to as few wards as possible, and every effort should be made to curtail the use of these methods."

Where it is necessary to restrain patients or place them in seclusion, the report stipulated a protective procedure to be followed.

The greater portion of the survey was given over to a review of the present setup of individual institutions and specific recommendations for their improvement.

Following are additional specific recommendations and comments of the report that may be of general interest to physicians:

The laws pertaining to mental health and related subjects should be brought together and arranged in proper order. A properly indexed pamphlet containing these laws, similar to the one published in 1945, should be made available.

Every effort should be made to effect the patient's hospitalization at the earliest moment when a court commitment is necessary.

An emergency measure permitting the superintendent to admit patients upon receipt of a written statement signed by a physician, a police officer or a health officer for a period of not more than ten days would help prevent many patients from being detained in jail while awaiting a hearing.

The time limitations specified in the law governing the admissions of patients upon the certificate of two physicians (non-judicial procedure) seem to be unnecessary, and it is recommended that the law be rewritten.

A qualified psychiatrist should be designated as examining physician by the court when such an individual is available without undue expense.

The law requiring the court to get the superintendent's permission before committing persons seventy or more years of age was evidently designed to protect inadequate mental health services. It is undesirable for several reasons.

The law making possible the release of suitable patients on trial visit does not place a limit on the time spent on trial visit. Twelve months is considerad to be sufficient by most authorities.

MENTALLY DEFICIENT

The hospitals at Apple Creek and Cambridge are caring for several hundred mentally deficient persons. The facilities at these institutions are needed for the care of the mentally ill.

Additional facilities for the care of the mental defectives should be provided in the northern part of the state. Institutions should be established in the Cleveland, Cincinnati and Toledo areas.

The facilities at Mt. Vernon should be increased to a point where all active cases of tuberculosis among mental institution patients can be cared for at that hospital.

Special facilities should be provided at all of the state hospitals for care of suspects and arrested cases of tuberculosis.

FACILITIES FOR CHILDREN

Adequate facilities for the care of psychotic and emotionally disturbed children should be established in the different sections of the state in connection with (a) a children's diagnostic and treatment center, (b) the pediatric section of a general hospital, or (c) a state hospital. Of these, the first is most desirable. Facilities for in-patient, out-patient and day care should be provided.

Although the law makes provision for the indefinite commitment of defective delinquents,

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special facilities have not been provided for members of this group and it is supposed that they are being cared for without segregation in the different institutions.

A study which would reveal the magnitude of the defective delinquent problem should be made.

Special facilities should be provided for the care of defective delinquents at the Lima State Hospital.

A new building recently opened at Lima is used to house sociopaths (psychopaths) at present. It does not provide facilities for treatment or occupation and the day space available is limited. The result is an undesirable degree of inactivity.

THE NUMBER OF MENTAL HOSPITALS

Ohio has a population of more than 8,000,000 people. It is divided into 11 mental hospital districts. Four of these districts each have a state hospital and receiving hospital which is located off the state hospital grounds. Two receiving hospitals in two other districts which will be off the grounds of the state hospital also are under construction and will be opened for the reception of patients soon. Three districts have state hospitals with the receiving hospital on the grounds. These are operated under the supervision of the superintendent of the state hospital. Two districts, Tiffin and Massillon, do not have receiving hospitals. Mt. Vernon and Lima have not been assigned districts as they receive patients from all parts of the state.

The population of the different districts is approximately as follows: Athens, 488,000; Cambridge, 375,000; Columbus, 988,000; Dayton, 680,000; Apple Creek, 690,000; Cincinnati, 945,000; Cleveland, 935,000 (metropolitan area of the city of Cleveland); Hawthornden, 577,345; Massillon, 1,049,000; Tiffin, 242,000; and Toledo, 977,000.

It is generally conceded that well located, comparatively small mental hospitals, 1,500-2,000 beds, are desirable for many reasons, both administrative and medical. Five of Ohio's mental hospitals have already a population of more than 2,000 patients, and others will have also if steps are not taken to provide additional facilities immediately.

The capacity of the Ohio State Hospitals according to the standards of the American Psychiatric Association is compared with the actual number of patients in the respective hospitals in the following table:

Hospital	Number of Patients	APA Capacity
Apple Creek	1,515	1,219
Athens	1,740	1,748
Cambridge	2,361	1,748
Columbus	2,548	1,832
Cleveland	2,764	1,511
Dayton	1,681	1,272
Hawthornden	1,294	1,453
Lima—Criminal	1,226	1,076
Longview (Cincinnati)	3,256	1,803
Mt. Vernon—T. B.	585	536
Massillon	3,194	1,847
Tiffin	599	572
Toledo	2,838	1,962

Venereal Control Program in Ohio Is Shifting to Private Physicians

The venereal disease control program is more and more shifting away from public health clinics and more to the private physician, according to Dr. Frederick H. Wentworth, chief of the Division of Communicable Diseases of the Ohio Department of Health.

In requesting that Ohio physicians continue their cooperation with health officials, Dr. Wentworth pointed out that the majority of venereal diseases are now reported by the practitioner. The largest change has occurred in the reporting of primary and secondary cases. In 1952 only 38 per cent of the syphilis cases in Ohio were reported by private physicians. So far in 1954, 55 per cent of these cases have been reported by private physicians.

"Our efforts should be aimed at stimulating the interests of private physicians in the venereal disease control program and of assisting them in every possible way to cope with it," Dr. Wentworth said. "We have, therefore, during the past several months made various attempts to improve health department-private physicians cooperation and liaison."

This cooperation has been appreciated and physician response has been excellent, he continued. The accuracy with which reports of venereal diseases are completed has been improved by 20 per cent.

There are available in the Venereal Disease Control Unit of the Ohio Department of Health copies of the latest generally accepted treatment schedules for venereal diseases. These are available upon request without charge to all physicians and they are sent out routinely to any physician who requests penicillin for the treatment of syphilis or gonorrhea in his patients.

In addition to this service, personal visits by the trained venereal disease control personnel may also be requested by contacting the Venereal Disease Control Unit, Division of Communicable Diseases, Ohio Department of Health.

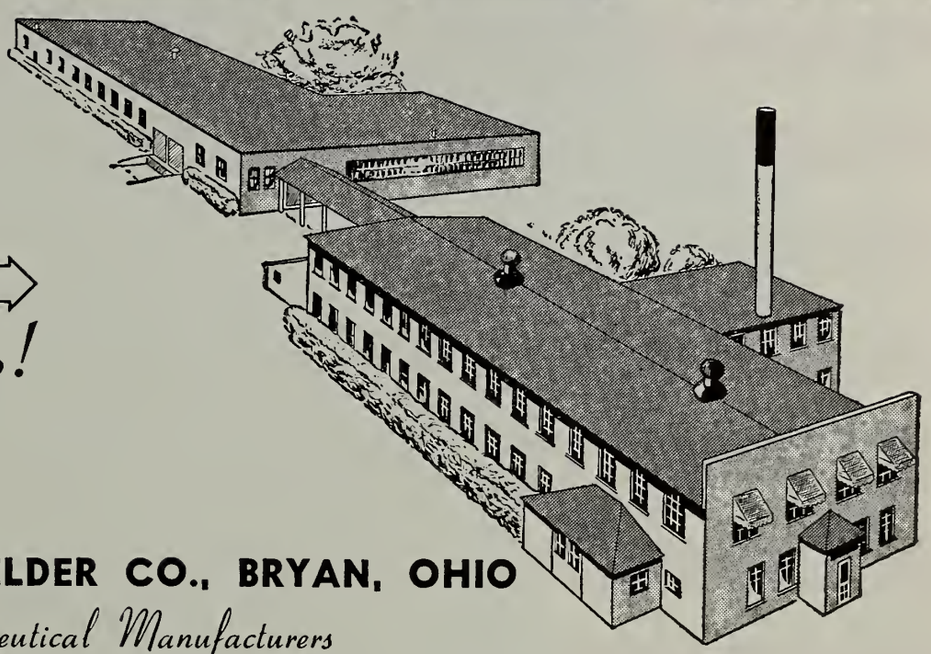
Dr. Ernstene To Be Speaker at West Virginia Heart Meeting

Dr. A. Carlton Ernstene, Cleveland, will be one of the featured speakers at the annual meeting of the West Virginia Heart Association in Huntington on Friday, November 5, at the Frederick Hotel.

He and Dr. E. Cowles Andrus, president of the American Heart Association, will conduct a wet clinic at St. Mary's Hospital in the morning and a scientific program in the afternoon. Banquet and evening meeting for the public follows.

Additional information may be obtained from the West Virginia Heart Association, 1206 Kanawha Blvd. E., Charleston, W. Va.

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Dr. Forman To Be Headline Speaker At Medical Writers' Meeting

Dr. Jonathan Forman, Editor of *The Journal*, will be the principal speaker at the evening meeting of the American Medical Writers' Association at the Hotel Sherman, Chicago, September 24. His subject at that time will be "A Newer Concept of Disease (Curative Versus Creative Medicine.)"

At the morning session, Dr. Forman will take part in a panel discussion on the subject, "Collegiate Education in Medical Journalism Writing," his theme being "What Medical Journals Expect from the New Collegiate Courses."

Another Ohioan will take part on the same panel. He is Dr. Raymond C. Pogge, director of medical research for the William S. Merrell Company in Cincinnati, whose subject will be "What Pharmaceutical Companies Expect from the New Collegiate Courses in Medical Journalism and Writing."

Closely associated with the foregoing meeting will be the 19th Annual Meeting of the Mississippi Valley Medical Society, September 22-24, also in the Hotel Sherman.

Additional information on both of these meetings may be obtained from Dr. Harold Swanberg, secretary of both organizations, 209-224 W. C. U. Bldg., Quincy, Ill.

Dayton Team Would Like To Contact Other Physician Skeet Shooters

A team of physicians of the Montgomery County Medical Society has worked up quite an interest in skeet shooting, with competition becoming rather keen. One of their members, Dr. R. K. Bartholomew, recently won two awards at Columbus in state-wide competition.

It occurred to some of them that members of other County Medical Societies perhaps have similar teams and that inter-Society matches might be arranged. In fact Montgomery County physicians threw a little challenge into their invitation by offering to take on all comers.

Dr. Bartholomew may be contacted at 1120 Fidelity Bldg., Dayton 2, Ohio; Phone AD 5161.

Western Reserve University was given insulin grant by Eli Lilly and Company for an investigation of the mechanism of the action of hormones, studying primarily the hyperglycemic factor and epinephrine, under direction of Dr. E. W. Sutherland, Jr., professor of pharmacology, School of Medicine.

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You and Your Public . . .

A. M. A. Offers Some Good Pointers on What May Be Considered Fair Fees for Physicians To Charge; Local Situation Is All Important

THE Public Relations Department often receives questions from young physicians entering practice with regard to the determination of the fees they should charge.

A recent article prepared by the Department of Public Relations of the American Medical Association and appearing in *The Journal of the American Medical Association*, is presented below as of interest to all physicians.

The best way to arrive at a fair scale of fees is to check with the county medical society and other physicians. Fees differ somewhat in various communities and in different parts of the country.

Many medical societies have worked up informal, unpublicized average fee schedules that can serve as a guide to local physicians in setting their charges. Some societies are publicizing average fee schedules so that patients know about how much a physician should charge for such routine medical procedures as office, house, or hospital calls. These schedules serve as a yardstick by which to measure fees.

The old philosophy of charging the wealthy more for their medical care in order to provide charity to the needy is fast fading. Any ethical physician will donate his care to those who are unable to pay if he knows the circumstances. Today most physicians have informal fee schedules of their own—sometimes existing only in their heads—based on their actual experience in the community. They charge a fee that can be lowered or cancelled under certain circumstances.

CIRCUMSTANCE MUST BE CONSIDERED

Though every doctor should charge enough to command respect, his fees should be reasonable and consistent with the average patient's ability to pay.

A physician sells his time and his services, but he cannot set his fees on the basis of the time spent per patient. Nor can his fee for an intangible service be compared with the price of a piece of merchandise.

Because every patient is different, medicine must be practiced on a personalized basis. Medical care has little value except to the patient himself—therefore, values of similar services differ. No one but the doctor himself is in a position to estimate the value of these services. Sometimes a patient may question a medical fee. Many physicians then say: "This seems to me to be a fair fee for your case, but you pay me what you think it is worth." Nearly every physician who uses this method reports that the patient will pay the original sum asked and sometimes will pay a little more.

A FAIR PROFIT

Once he has established a fee, a physician should adjust charges only on a cost basis. According to a professional management official, 15 per cent to 20 per cent is a fair profit for a physician. Sometimes he can cut his fees on an efficiency basis. It is impossible to put bargain rates on good medical care, but every doctor can strive to give better medical service per dollar and should remember that he is never successful because of the price he places on his services—he is successful only because he is a good doctor doing a good job.

SOME TIPS ON SETTING FEES

Here, in brief, are tips on how to set fees fairly:

1. Check with the county medical society to learn what average fees are in the area.
2. Check with other physicians to learn what fees are charged.
3. Charge a reasonable fee that can be lowered or cancelled if circumstances warrant.
4. Charge enough to command respect.
5. Set fees consistent with the average patient's ability to pay.
6. Adjust fees on a cost basis only.
7. Do not put bargain rates on medical care; this tends to lower quality.
8. Give the best medical service possible per dollar.

Ohio State Medical College Gets $10,000 Student Loan Fund

Because of a series of circumstances Ohio State University College of Medicine will receive $10,000 from the recent nationwide Auto-Lite Family Charity Drawing.

Number One winner in the drawing was Mrs. Desse L. Irish who was given the privilege of allocating $50,000 of the prize money to worthy causes. Mrs. Irish is the daughter-in-law of Dr. Cullen W. Irish, Los Angeles, Calif., a 1915 graduate of the O. S. U. College of Medicine. She designated $10,000 of the total amount in the name of Dr. Irish as a loan fund for O. S. U. senior medical students and residents in the field of psychiatry, neurosurgery and neurology. The money will come from the Electric Auto-Lite Company of Toledo.

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In Memoriam . . .

Harvey T. Phillips, M. D., Athens; Starling Medical College, Columbus, 1900; aged 82; died July 31; member of the Ohio State Medical Association; member of the American Medical Association; vice-president and president of the Athens County Medical Society in 1930 and 1931, respectively; also active on several local committees, particularly the legislative committee. Dr. Phillips, in addition to his medical practice, served his community and the state on numerous occasions in public office. He served Athens County as its coroner in 1910 and then was elected probate judge, serving two four-year terms. He served in both houses of the state legislature, being named to the House of Representatives in 1935 and to the State Senate in 1938. He was medical examiner for the Industrial Commission for two years and then became Athens County health commissioner, a post he held from 1944 to 1948. He was a member of the Christian Church and active in several Masonic bodies. Survivors include his widow, two daughters, and a sister.



H. T. PHILLIPS, M. D.

Charles A. Barrow, M. D., Lancaster; Kentucky School of Medicine, 1893; aged 89; died July 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Barrow's practice extended over a period of 61 years. He began his practice at New Straitsville where he had previously lived. After 17 years he moved to Carroll, and again in 1926 moved to Lancaster. He was a member of the Masonic Lodge and the Knights of Pythias. Two daughters and a son survive.

Harmon E. Blott, M. D., Youngstown; Western Reserve University School of Medicine, 1888; aged 89; died July 24; former member of the Ohio State Medical Association. At the time of his retirement in 1943 Dr. Blott had practiced a total of 55 years, all of it in the Youngstown area. He was a former Mahoning County coroner, was active in the local medical society and was a member of the board of education. Surviving are his widow, a daughter and a son, Dr. Myron S. Blott, of Youngstown.

Elmer A. George, M. D., Cleveland; Western Reserve University School of Medicine, 1914; aged 68; died July 29; member of the Ohio State Medical Association through 1952. A life resident of the Greater Cleveland area, Dr. George practiced there for more than 40 years. For the last 15 years he had been a physician in the Children's Hygiene Division of the Cleveland Health Department. For many years also, he was physician for the Cleveland Board of Education. Surviving are his widow, a daughter and a son, Dr. Robert A. George.

William Eugene Hall, M. D., Massillon; Barnes Medical College, St. Louis, 1900; aged 77; died July 10. Dr. Hall practiced for approximately 14 years in Massillon where he was a former city health commissioner. Dr. Hall retired from service with the Army Medical Corps in 1940 with the rank of Colonel. He was a member of the American Legion. Surviving are his widow and a daughter.

John Martin Jones, M. D., Millersburg; Starling Medical College, Columbus, 1895; aged 83; died July 6; member of the Ohio State Medical Association and the American Medical Association. A practicing physician since before the turn of the century, Dr. Jones had been honored with the 50-Year Pin of the Ohio State Medical Association. Dr. Jones moved to Millersburg in 1929 from Glenmont where he had assumed his father's practice. Surviving are his widow, four daughters and two sons.

Emma Jean Pearson Randall, M. D., Toledo; University of Michigan Medical School, 1899. A native of Van Wert, Dr. Randall returned there to practice upon completion of her medical education. She later married Dr. Floyd Randall and went with him to Bay City, Mich. Upon the death of her husband 10 years ago, she returned to Van Wert and moved to Toledo about three years ago. Survivors include two brothers.

Albert Eugene Schwallie, M. D., Ripley; Cornell University Medical College, 1910; aged 75; died July 8; former member of the Ohio State Medical Association, last in 1928. Dr. Schwallie practiced in Brown County from the early 1920's until his retirement about three years ago. He was a member of the Catholic Church. Only distant relatives survive.

Clarence Edward Shepard, M. D., Sulphur Grove (Dayton P. O.); Ohio State University College of Medicine, 1909; aged 70; died July 14; member of the Ohio State Medical Association; former member of the American Medical Association; vice-president of the Montgomery County Medical Society in 1931. A native of Montgomery County, Dr. Shepard had practiced for 45 years in the Sulphur Grove area. He had served on the Montgomery County Board of Health for 15 years. Survivors include his widow and two sons, one of whom is Dr. Ned O. Shepard, of Dayton.



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New Hospital Regulations . . .

Adopted by Ohio Public Health Council and Effective July 1, Setting Up Minimum Standards for General Hospitals As Required by New State Law

AMENDED Substitute House Bill 665 was passed by the Ohio General Assembly in July, 1953, and signed by the Governor, assigning to the Ohio Department of Health the responsibility of establishing and maintaining minimal standards for Ohio hospitals not already subject to licensing or statutory approval. The exemption applies to maternity and lying-in hospitals, tuberculosis and institutions providing hospital services for the mentally ill.

Immediately following the effective date of the bill the Hospital Advisory Board to the Ohio Department of Health, met at the request of the Director and appointed a subcommittee to aid in drafting minimum hospital standards which the Department could submit to the Public Health Council.

A subcommittee of the Hospital Advisory Board presented to Doctor John D. Porterfield, then Director, a draft of the proposed regulations and recommended their adoption. The Director submitted the recommendations to the Public Health Council in April of 1954. A public hearing was held on June 12. With some amendments, the regulations were adopted, becoming legally effective July 1, 1954.

DR. DWORK'S COMMENTS

In an address on July 15 before the Ohio Hospital Association Workshop on Hospital Accreditation, Columbus, Dr. Ralph E. Dwork, acting Director of Health, discussed the newly adopted regulations. In his remarks, Dr. Dwork said in part:

"In our opinion the regulations are truly minimal, intended to work no deliberate hardships on anyone. They do, indeed, fall far short of anything which the Joint Commission on Accreditation expects and requires. The reason for this is obvious. The Joint Commission will not consider facilities with less than twenty-five adult beds; whereas, for our purposes, anything more than two beds would have to be scrutinized. Accreditation by the Joint Commission is voluntary, the hospitals applying to the Commission Director for such review. The state program permits no such discretion.

SEEKS COOPERATIVE ATTITUDE

"It seems to me that this business of setting and maintaining standards is wholesome. I should much prefer a completely voluntary compliance program such as that represented by the Joint Commission. We in the State Health Department do not wish to police the hospitals of the state. Even if we wished, it is not likely that we would ever have the money or the personnel to do so. We would very much prefer to have you call upon us for consultation service, in the form of advice and statistical information, planning, and evaluation.

"In keeping with this view, it is our intention to accept without hesitation, the accreditation of the Joint Commission as meeting our requirements, though an annual visit is required by law. For those hospitals who do not apply or cannot meet the requirements of the Commission, the Division of Hospital Facilities of the Ohio Department of Health will of necessity make its own determination. We shall shortly be preparing check list questions not unlike those of the Joint Commission but based on our own regulations. Our department personnel will follow these guides as they visit and survey your institutions.

CERTIFICATE OF COMPLIANCE

"I would like to say that the enactment of Amended Substitute House Bill No. 665 and the Public Health Council's regulations promulgated thereunder, are not considered in any way as a licensure law for general hospitals. When our annual visit indicates that an institution has complied with the standards, a "Certificate of Compliance" will be issued. This is not to be construed as a license.

"If a hospital does **not** meet the standards, there is no penalty provided other than the penalty for a violation of a regulation of the Ohio Sanitary Code. (A maximum fine of $100.00.) We are, of course, duty bound to make known to the public those hospitals which have been accredited by our department. It is conceivable that the Industrial Commission, private insurers, and others may, through their own policies, refuse to pay for hospitalization in non-accredited institutions. It is our hope that this will not occur. We hope, instead, that those Ohio hospitals which do not now meet minimum standards will improve and will reach minimum or better standards of operation. It is not the intent of the legislation or of our department to close up hospitals because they are not complying with the new standards. The entire program is geared to an effort to help all Ohio hospitals in achieving better patient care."

Following is the text of Regulations 400 to 415, inclusive, as adopted by the Public Health Council and effective last July 1:

DEFINITIONS

Regulation 400. (Definitions.) The interpretation and determination of compliance with mini-

mum standards for the maintenance and operation of subject voluntary and governmental hospitals, promulgated under section 3701.72 of the Revised Code, shall be within the discretion of the director of health.

As used in regulations 400 to 415, inclusive:

(A) "Administrator" means the executive agent of the board;

(B) "Bed capacity" means the maximum number of beds which can be accommodated within the physical structure of a hospital;

(C) "Bed complement" means the number of beds available for use by hospital inpatients and normally used to determine bed occupancy. This does not include bassinets, labor beds, and observation or recovery beds;

(D) "Board" means the governing board or other organized body representing the authority of a hospital;

(E) "Department" means the department of health;

(F) "Director" means the director of health;

(G) "Hospital" means any subject voluntary or governmental institution offering services and facilities for use beyond a twenty-four hour period by two or more unrelated persons who require diagnosis, treatment, or care of illness, injury, deformity, infirmity, abnormality, or pregnancy.

Such institution shall provide bedside nursing and dietary service and also make available medical care under an organized medical staff. A registered professional nurse shall be in attendance and on duty at all times and there shall be provided regularly the minimum of clinical laboratory services, x-ray services, and adequate facilities for the performance of surgery and for other medical services offered in the hospital.

Such institutions, whether they be proprietary, nonprofit, religious, or under any other ownership, shall be classified as either voluntary or governmental hospitals, except those institutions licensed or approved under other existing statutes;

(H) "Medical staff" means those qualified individuals who provide medical service;

(I) "Nursing staff" means the group of qualified individuals employed for the purpose of providing nursing service;

(J) "Utility room" means an area for the safe accommodation of clean or soiled equipment and supplies used in the care of patients of a given nursing unit.

GOVERNING BOARD

Regulation 401. (Governing Board.)

The board shall formulate all policies for the administration of the hospital and shall appoint

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an administrator who shall execute such policies. The board shall:

(A) Establish procedures governing visitation to the hospital.

(B) Establish written procedures for fire drills.

(C) Establish procedures whereby a competent physician shall be available at all times for care of inpatients in need of medical services.

(D) Require that each employee of the hospital, at the time of his employment and at least once annually thereafter, receive a physical examination to determine physical fitness for employment, including a chest x-ray and serological test for syphilis.

(E) Require that each voluntary worker giving bedside care shall be subject to the physical examinations provided for in Regulation 401 (D).

ADMINISTRATION

Regulation 402. (Administrator.)

The administrator shall execute all policies, rules, and regulations adopted by the board. He shall not knowingly employ a person suspected of having or being a carrier of a communicable disease.

PHYSICAL FACILITIES

Regulation 403. (Physical facilities.)

Each hospital shall provide physical facilities maintained in a reasonably safe and sanitary manner, free from fire and accident hazards. The physical facilities shall include:

(A) Adequate equipment, light, and ventilation to permit reasonably safe and proper operation of the hospital;

(B) Suitable standby equipment for emergency electrical needs for use in critical areas in the hospital;

(C) A minimum of eighty square feet of floor area for each one-patient room; not less than sixty square feet of floor area per bed in multiple patient rooms with not less than three feet of floor space between beds. Patient rooms shall not extend more than three feet below the ground level;

(D) Adequate means of communication to the nursing station within easy access of each patient bed;

(E) Suitable and properly equipped areas for the isolation of patients having or suspected of having a communicable disease;

(F) Handwashing facilities, soap, sanitary towels, and hot and cold running water in all areas assigned for the specific purpose of examination, isolation, utility, or treatment;

(G) A fire door to close any entrance connecting the hospital with a boiler room;

(H) Specially assigned separate areas for the storage of oxygen and anesthetic gases. These areas shall be so located and ventilated as to provide safety for both patients and personnel;

(I) Adequate utility, service, and storage rooms properly illuminated and ventilated;

(J) Handrails at all steps;

(K) Adequate dressing rooms for staff and personnel;

(L) Corridors of adequate width to permit the transportation of nonambulatory patients;

(M) An elevator of adequate size to transport non-ambulatory patients safely when the structure contains patient areas above access level.

MORGUE AND AUTOPSY

Regulation 404. (Morgue and Autopsy.)

Any hospital providing morgue or autopsy facilities, or both shall locate such facilities in an area of the hospital sufficiently remote from contact with the general public that such facilities remain reasonably inconspicuous and unoffensive to visitors and other invitees.

Such facilities shall be ventilated in a manner sufficient to prevent harmful, noxious, offensive air or odors from being circulated within the hospital or within proximity of any facilities used or occupied by patients.

All utilities deemed essential by the director shall be provided.

X-RAY

Regulation 405. (X-Ray.)

All x-ray facilities shall be under the direct supervision of a physician experienced in radiology. Such facilities shall provide sufficient space for proper performance of radiologic services and shall be so constructed and arranged as to afford reasonable protection to the patient, operator, and other personnel against radiation and electrical hazards. Similar supervision and facilities shall be maintained in the handling of radio-active materials.

PHARMACY

Regulation 406. (Pharmacy.)

The compounding of prescriptions in a hospital shall be by a pharmacist, duly registered by the state board of pharmacy, under the provisions of sections 4729.01 to 4729.35, inclusive, of the Revised Code.

FOOD SERVICE

Regulation 407. (Food service.)

Food service operations in any hospital shall be conducted and maintained in accordance with the provisions of regulations 300 to 305, inclusive, of the Ohio sanitary code.

STERILE SUPPLIES

Regulation 408. (Sterile supplies.)

Any facility for sterilization or for storage of sterile supplies shall be under the direct supervision of a qualified person.

Such facility shall provide sufficient space and equipment for proper cleaning, sterilization, and

storage. Heat, light, and ventilation shall be adequate for such cleaning, sterilization, and storage.

SURGERY

Regulation 409. (Surgery.)

Any facility for the performance of surgery shall:

(A) Be separated from all other service areas;

(B) Include sufficient space properly equipped for the operating procedures, including scrub-up facilities and utility rooms;

(C) Provide reasonable precaution to minimize fire and explosion hazards.

(1) There shall be no smoking in any operating area.

NURSING STAFF

Regulation 410. (Nursing staff.)

The nursing staff shall:

(A) Be under the general supervision of the administrator of the hospital;

(B) Be under the direct supervision of a director of nurses who shall be a nurse registered in the state of Ohio, under the provisions of sections 4723.01 to 4723.24, inclusive, of the Revised Code;

(C) Be composed of an adequate number of trained personnel to provide patient care.

MEDICAL STAFF

Regulation 411. (Medical staff.)

The medical staff shall:

(A) If composed of three or more physicians, be an organized group which shall, with the approval of the board, formulate and adopt rules, regulations, and policies which shall specifically provide for:

(1) Annual appointment or election of a member of the medical staff to function as chairman of staff;

(2) Review and analysis of clinical experiences at regular intervals;

(3) Review of the administration of medicines and treatments to all patients;

(4) Supervision of all anesthesia in accordance with sections 4731.01 to 4731.50, both inclusive, of the Revised Code.

MEDICAL RECORDS

Regulation 412. (Medical records).

The medical records shall:

(A) Contain sufficient data written in sequence of events to describe the basis for diagnosis and treatment of the patient concerned;

(B) Be treated as privileged documents in accordance with section 2317.02 of the Revised Code.

INSPECTION

Regulation 413. (Inspection and issuance of certificate of compliance.)

(A) An annual inspection of each hospital, and such other inspections as in the discretion of the director may be required, shall be made by the director or by his duly authorized representative;

(B) A certificate of compliance, signed by the director and sealed with the official seal of the department, shall be issued to the owner or operator of each hospital when the determination has been made that it is maintaining the minimum standards adopted by the public health council. The form of such certificate shall be prescribed by the director and the certificate shall be posted in a conspicuous place on the hospital premises. Such certificate shall not be effective for a period of longer than one year from the date of issue and it shall be revoked by the director for the failure of the hospital to maintain such minimum standards.

UNLAWFUL OPERATION

Regulation 414. (Unlawful operation.)

It shall be unlawful for any person, corporation, or other organization, not having met the requirements of regulation 413 and not holding the certificate provided for in such regulation, to operate or manage a hospital in this state.

PENALTY

Regulation 415. (Penalty.)

Whoever violates any provision of regulations 400 to 414, inclusive, shall be subject to the penalties provided in section 3707.99 of the Revised Code. (Note: maximum fine, $100.)

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D., MIDDLETOWN)

CLERMONT

Members of the Clermont County Medical Society joined the Williamsburg community in a celebration for Dr. J. P. Allen for his more than 56 years service to the people of the area. He had previously been honored with the 50-Year Award of the Ohio State Medical Association.

CLINTON

A discussion of gamma globulin as a preventive for polio was given by Dr. Henry M. Brown, Clinton County health commissioner, at the July 13 meeting of the Clinton County Medical Society in Wilmington. A discussion of coronary artery disease also was part of the program.

HAMILTON

The annual meeting of the Academy of Medicine of Cincinnati is scheduled for September 21 at 8:30 p. m. in the College of Medicine Auditorium.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

LAKE

Dr. J. L. Reycraft, Cleveland, spoke on the topic, "Induction of Labor," at the July meeting of the Lake County Medical Society in Painesville.

At a business session presided over by Dr. W. H. Willis, president, recommendations to the public in regard to availability of physicians were made public through the local newspaper. Points covered in the recommendations were:

1. That every family make contact for a private physician or family doctor before sickness develops—especially those families which are new in the community.

2. That there is a medical call bureau in Painesville to which most physicians in Lake County belong. Most of the doctors, it was explained, have two or more of their colleagues who cover for them on their days off or during vacation.

3. There is a committee of the Lake County Medical Society to handle complaints by patients concerning doctors.

4. There is a physician on call at the hospital for emergency purposes at all times, on a rotation basis.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

TUSCARAWAS

Twenty-three members and three guests, with their families, attended a picnic dinner and outing on July 14, with Dr. and Mrs. Harold F. Wherley as host and hostess at their Sugarcreek home. Dr. Clark M. Dougherty and Mrs. Paul D. Hahn were on the planning committee.

The August 12 meeting was in the Union Hospital Auditorium. Guest speaker was Dr. Norman P. Shumway, Western Reserve University School of Medicine and chief of medicine at the Veterans Administration Hospital, Cleveland, who discussed indications and precautions in the use of cortisone.

Bucyrus—Dr. H. H. Hartmann, Galion, was the subject of a feature article in the *Bucyrus Telegraph-Forum*—the occasion being the 64th anniversary of his graduation from medical school.

Jackson—Dr. Herbert Chamberlain, McArthur, spoke before the Jackson Rotary Club, where he described his experiences with infant immunizations.

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Activities of Woman's Auxiliary . . .

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President-Elect—Mrs. Karl Ritter, 1420 Shawnee Rd., Lima, Ohio
Vice-President—Mrs. Charles Obert, 20710 Park Cliff Drive, Fairview Park, Cleveland 26, Ohio
Recording Secretary—Mrs. S. L. Meltzer, 2442 Dorman Dr., Portsmouth, Ohio
Corresponding Secretary—Mrs. John Dickie, 2215 Parkwood Ave., Toledo, Ohio
Treasurer—Mrs. Herbert Van Epps, 435 E. 15th St., Dover, Ohio
Past President—Mrs. N. M. Reiff, 404 Rawlings St., Washington Court House, Ohio

SUMMIT

The members of the Woman's Auxiliary to the Summit County Medical Society are proud to announce their project "Hobby Show for Oldsters" was selected as a topic for one of the Public Relation panels at the National Convention in San Francisco in June. The show this year will be held in O'Neil's Auditorium on September 10, 11 and 13. It is jointly sponsored by the United Community Council and the Medical Society Auxiliary. Any person 65 years of age or older, is eligible to display his or her particular hobby at the show. Awards will be given in many classifications and this year's show will have innovations that will appeal to the oldsters in the Akron district. Mrs. Ralph Sommerfield heads the committee for the Hobby Show and states that early applications indicate that an unusual diversification will give interest to the exhibit.

The summer months do not bring complete relaxation to members of the Summit County Medical Auxiliary, they continue their activities throughout the year. In July the final data in connection with the Diabetes Test made earlier in the year, were collected by Auxiliary members. Helping to make this project a success were the Medical Advisory Committee, clerks from the Summit County Tuberculosis and Health Association, the Akron Health Department, and the Medical Society Auxiliary under Mrs. A. Dobkin.

The Summit County Tuberculosis and Health Association and the Summit County Medical Society Auxiliary have teamed up to place health pamphlets in doctors' offices. They have found that people like to read this type of literature while waiting for their doctor. The TB Association has developed a plastic pamphlet holder to set on a table. The Medical Auxiliary has agreed to distribute them and to service them monthly with a new supply of health news.

Piqua—Dr. Ralph D. Yates was named president of the medical staff of Piqua Memorial Hospital, with Dr. W. W. Trostel, vice-president, and Dr. Gerard F. Wolf, secretary-treasurer.

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Do You Know . . .

Dr. William F. Ashe, newly appointed chairman of the Department of Preventive Medicine, Ohio State University, left late in August for a six weeks' assignment in India for the Foreign Operations Administration on a Point Four project. There he will study ailments of workers in the steel and textile mills as to cause.

* * *

Dr. Robert Green, Cincinnati, was elected president-elect of the National Medical Veterans Society at the meeting of that organization in San Francisco.

* * *

A nonprofit organization to perpetuate the ideals of the late Senator Robert A. Taft has been founded with President Eisenhower as honorary chairman and former President Hoover as chairman. With headquarters in Washington, the foundation will use its funds for religious, charitable, scientific, literary and educational purposes.

* * *

Dr. Richard D. Bryant, associate professor of obstetrics in the University of Cincinnati College of Medicine, late in July spoke before the International Conference on Obstetrics and Gynecology in Geneva, Switzerland, on the subject, "The Toxemia of Pregnancy." He explained the research going on at U. C. in this field.

* * *

Dr. Richard E. Goldsmith, assistant clinical professor of medicine, University of Cincinnati, presented a paper on "The Machanism of the Iodide Induced Remission in Thyrotoxicosis" before the Endocrine Society which met in San Francisco.

* * *

In early August poliomyelitis cases were running 7 per cent behind the total reported to the same time last year, the U. S. Public Health Service announced. For the first 7 months of this year, 9,185 cases were reported, compared with 9,840 cases for the same period last year. Both years are far below the record of 10,582 cases reported in the first 7 months of 1952.

* * *

Dr. Joseph B. Stocklen, Cleveland, Cuyahoga County Tuberculosis comptroller, spent six weeks in Alaska this summer as part of a team studying TB control methods among natives of outlying villages.

* * *

Dr. Stewart Jones, Cincinnati, was elected president of the Ohio Valley Proctologic Society which met recently in Springfield. Dr. A. Clyde Ross, also of Cincinnati, was elected secretary-treasurer. The group is composed of physicians of Ohio, Kentucky, Indiana, West Virginia and a section of Pennsylvania.

Medicine-as-Career Film

"Your Future in the Professions—Doctors," a 35-mm. film strip, is a "natural" for high school guidance and health education programs. It points up to the student the most important considerations in selecting medicine as a career. The final sequence presents several topics for discussion between viewers and the physician conducting the program.

The film has been produced by the Society for Visual Education in cooperation with the American Medical Association. The Ohio State Medical Association has a copy of this strip for loan.

Fortieth Annual Clinical Congress American College of Surgeons

The largest and most widely instructive meeting of surgeons in the world, the 40th annual Clinical Congress of the American College of Surgeons, will be held in Atlantic City, New Jersey, November 15 to 19. More than 10,000 Fellows of the College and their guests from all over the world will gather to fulfill the purposes of this Congress: to discover, to inform and to learn. This postgraduate education meeting will present recent surgical developments through a wide variety of programs, including panel discussions, symposia, surgical forums, motion pictures, cine clinics, color television and exhibits. Dr. Charles deT. Shivers, Atlantic City, is chairman of the Atlantic Advisory Committee on Arrangements.

Dr. Frank Glenn, New York, current President of the American College of Surgeons, will preside at the opening evening session, at which Dr. Alan Gregg, New York, and Dr. Robert H. Kennedy, New York, will be guest speakers. On the final evening Dr. Alfred Blalock, Baltimore, will be installed as President for the coming year.

Dr. Evarts A. Graham of St. Louis is Chairman of the Board of Regents and Dr. Paul R. Hawley of Chicago is The Director.

Relax Law on Oral Prescribing

Congress has enacted a new law which permits oral prescription of certain narcotic compounds. The U. S. Commissioner of Narcotics will issue a list of drugs to which law will apply. It was supported by representatives of medical and pharmacy professions.

Wellington—Dr. A. C. Sidall, Oberlin, was guest speaker at a dinner meeting of the Business and Professional Women's Club, where he spoke on "Personal Safety."

Medical Care for Indigents . . .

Letter From Columbus To Member Outlines Customary Procedure and Recommends County Medical Society Group To Deal With Relief Agencies

RECENTLY the Columbus Office received an inquiry from a member regarding plans covering medical care for the indigent and citing certain difficulties he had encountered in securing payment for services he had rendered in his home town.

The answer from the Columbus Office digested the situation and offered the physician some sound advice. Parts of the reply are published here as they may enlighten other members on the relief set-up and aid them in dealing with such problems locally.

The inquiring physician asked: "What is the general practice of the various counties regarding payment of physicians for services for so-called indigent or welfare cases?"

LOCAL AGREEMENT

The answer given pointed out that in most counties of the state, physicians are being paid for their services to patients on poor relief, in accordance with the fee schedule agreed upon between the county welfare agency and the county medical society. In some of the metropolitan areas in which there are hospitals connected with the medical schools or in hospitals which have extensive resident-training programs, surgical care of the relief patients is without charge and is generally done by the residents on the hospital staff, it was stated.

The letter revealed that during the year 1953, a total of $7,180,468 was paid in Ohio for medical care and hospitalization of persons in the poor-relief category. Of that amount, $6,252,566 was paid for hospitalization and $927,902 to physicians, for medical and surgical care. Included in this latter amount was a relatively small figure for medicine and drugs.

"Is there a state law governing such matters or does each county formulate its own rules?" the doctor asked.

Answering this in the affirmative, the Columbus office pointed out that the responsibility for furnishing medical and hospital care to people on poor relief falls on the local political subdivision, city and county, under the general direction of the Division of Social Assistance of the State Department of Welfare.

Commenting on the problems cited by the physician, the Columbus Office suggested a "getting together of minds between the local welfare department and officials of the county medical society."

SOCIAL ADMINISTRATION RECOMMENDATIONS

Attention was called to an administrative manual issued by the State Division of Social Assistance for the information and guidance of local administrative welfare agencies, which in part states:

"Most counties in the state have some type of agreement between the local society and the local welfare office as to the fees for poor relief cases." Under the caption of "Fees for Medical Care," it is stated in the manual that each local relief authority should establish a schedule of fees for medical and dental care, upon which payments for such service will be based. Again under the caption "Medical and Hospital Advisory Committees," the Division of Social Administration strongly recommends that medical and hospital advisory committees be established in every county, to facilitate cooperation between the relief authorities and local physicians, dentists and hospitals. The manual goes on to say that one of the functions of that committee

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is the establishment of fee schedules for medical care.

The Columbus Office communication to the physician concluded with this comment: "With reference to the specific case in which you have had some difficulty, the relief authorities generally require authorization for surgery, except in an emergency. If your county society had a liaison committee with the county welfare agency, the circumstance of your case would be a very logical one to be brought up for consideration."

Osteopaths Say A. M. A. Committee May Visit Their Schools

The House of Delegates of the American Osteopathic Association, meeting in Toronto, July 15, approved on-campus visits of its schools by an A. M. A. Committee to determine the quality of medical education provided.

This step dates back to the A. M. A. House of Delegates session in 1952 when a Committee for the Study of Relations Between Osteopathy and Medicine, headed by A. M. A. Past-President John W. Cline, was created. At the A. M. A. June meeting in San Francisco this year, the Committee submitted "a progress report" to the Board of Trustees, which was later adopted by the House of Delegates.

The Committee's three-page typewritten report said that "the justification or lack of justification of the 'cultist' appellation of modern osteopathic education could be settled with finality and to the satisfaction of most fair-minded individuals by direct on-campus observation and study of osteopathic schools. The Committee, therefore, proposed to the Conference Committee of the American Osteopathic Association that it obtain permission for the Committee for the Study of Relations Between Osteopathy and Medicine to visit schools of osteopathy for this purpose."

Two other important paragraphs of the A. M. A.'s Committee report said:

"It was agreed that each school would be visited by two members of the Committee, accompanied by an individual of established experience in inspection of medical schools. The studies would be of sufficient duration, breadth and depth to establish the nature and scope of the educational program and determine the quality of medical education provided.

"The Conference Committee favorably recommended this proposal to the Board of Trustees of the American Osteopathic Association which considered it at a special meeting on February 6-7, 1954. It has referred the question to the House of Delegates which will act upon the proposal at its Toronto meeting in July. If the action of the House of Delegates of the American Osteopathic Association be favorable, the on-campus observations can be carried out in the fall of this year."

The action of the House of Delegates of the American Osteopathic Association was favorable. The Association issued a statement setting forth the action of its delegates. It said in part:

"The House of Delegates of the American Osteopathic Association in session in Toronto, July 15, 1954, directed the Conference Committee to continue its deliberations with the committee for the Study of Relations Between Osteopathy and Medicine of the American Medical Association.

"In expressing its confidence in the four years' work of the A. O. A. Conference Committee, the House agreed that the Committee should have the authority to negotiate with the A. M. A. Committee on possible visitation by the latter of osteopathic colleges. The purpose of this visitation would be to observe the nature and scope of their education programs. This observational opportunity would be conducted entirely within limits agreed upon by the two committees. The immediate purpose of such on-campus visitations is to provide information to the A. M. A. Committee to assist in its efforts to remove the cultist designation from the osteopathic profession."

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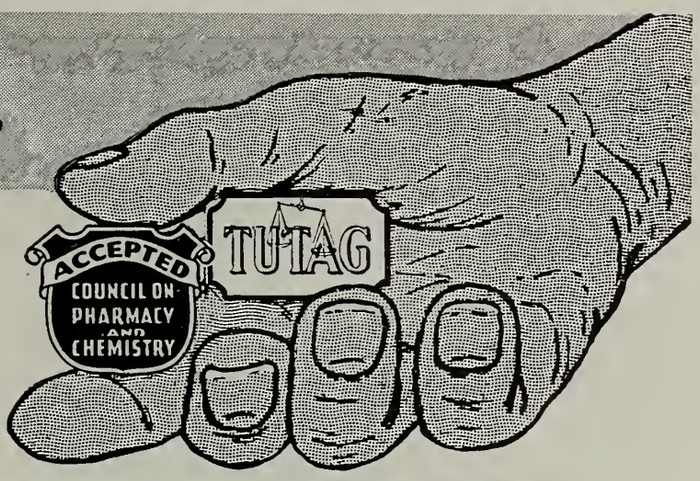
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Orientation Courses for Doctors . . .

Montgomery County Has Given Considerable Time to This Subject and Is Promoting an Annual Series of Meetings for Incoming Physicians

THIS year for the third consecutive year the Montgomery County Medical Society gave a series of orientation lectures for new members. The series consists of six meetings of 1½ hours each, under the supervision of a committee appointed for that purpose.

It is interesting to note that these meetings are considered so important locally that the Society's Council has recommended a revision of the constitution making attendance at the lectures a requirement for admission to active membership. Also, it is being proposed that applicants for membership be given an associate membership in the county society for one year with all privileges except the right to vote or hold office. Associate membership automatically expires at the end of 12 months, at which time application for active membership may be made.

SERIES OF SESSIONS

The orientation series is divided into six sessions as follows:

Session 1—(a) Medical Organization—an explanation of the County Society, the Ohio State Medical Association and the American Medical Association; (b) Medical Ethics—an explanation of the Principles of Medical Ethics with emphasis on that portion dealing with relations with other physicians. Lecture and round-table discussion.

Session 2—Medical Ethics—a continuation of the first lecture on ethics with emphasis on that portion relating to doctor-patient relations—a panel discussion by three selected members.

Session 3—Religion and Medicine—a selected leading Protestant Minister, Priest and Rabbi are asked to serve on a panel. Each speaks for 15 minutes, after which a discussion is held. Points covered include responsibilities of the clergy to the patient; the doctor's relation to the minister: practice and tradition of the various religions in regard to birth, death, autopsy, circumcision, baptism, etc.

Session 4.—Community Responsibility—a lecture and discussion is conducted by a community relations director of one of the leading industrial firms. The role of the doctors in nonmedical community affairs is stressed.

Session 5—Fees—a discussion of the average fee, how fees are established, etc., by a panel consisting of a general practitioner, a surgeon, and a pediatrician and an obstetrician.

Session 6—Medicine and the Law—a lecture and discussion conducted by a lawyer on the legal problems of medical practice.

All new physicians in the county are invited to visit the headquarters office of the Montgomery County Medical Society where they may spend several hours discussing services of the Society and details of getting started in practice.

Several Ohio Physicians Hold Key Positions in A. M. A. Sections

At the American Medical Association Annual Session in San Francisco, a number of Ohio physicians were elected to key positions in the various Sections, according to the official proceedings of the meeting which were reported in *The Journal of the A. M. A.*, issues of July 10 through August 7. The following were elected as officers or delegates:

Dr. Rolland J. Whitacre, Cleveland, was named alternate delegate of the Section on Anesthesiology, and Dr. Lloyd E. Larrick, Cincinnati, was named one of the nominees to the American Board of Anesthesiology.

Dr. Robert D. Taylor, Cleveland, was elected alternate delegate of the Section on Experimental Medicine and Therapeutics.

Dr. A. Carlton Ernstene, Cleveland, was elected secretary of the Section on Internal Medicine.

Dr. Joseph P. Evans, Cincinnati, was elected vice-chairman of the Section on Nervous and Mental Diseases.

Dr. Walter J. Zeiter, Cleveland, was elected secretary of the Section on Physical Medicine and Rehabilitation.

Three Ohioans were elected by the Section on Preventive and Industrial Medicine and Public Health. Dr. John J. Phair, Cincinnati, was named chairman; Dr. Paul A. Davis, Akron, representative to the Scientific Exhibit and Dr. Frank Princi, Cincinnati, continued as secretary.

Dr. Robert M. Zollinger, Columbus, was elected chairman of the Section on Surgery, General and Abdominal.

Dr. Charles C. Higgins, Cleveland, was elected chairman of the Section on Urology.

Bill Only Sleeping—Not Dead

Oveta Culp Hobby, Secretary of Health, Education and Welfare, telling how her department fared in the current Congress, said: "We can't complain. The only setback was health reinsurance being recommitted. It was a new and novel idea, and many new and novel ideas don't get by the first time. I am not discouraged. Maybe we can write a better bill. Maybe we can be more specific."

COMING MEETINGS

Ohio State Medical Association, 1955 Annual Meeting, week of April 18, 1955, Cincinnati.

American Medical Association, 1955 Annual Meeting, June 6-10, 1955, Atlantic City, N. J.

American Medical Association, 1954 Clinical Meeting, Nov. 29- Dec. 2, 1954,, Miami, Fla.

American Congress of Physical Medicine and Rehabilitation, Sept. 6-11, Washington, D. C.

American Society of Clinical Pathologists, Sept. 6, Washington, D. C.

International College of Surgeons, Sept. 7-10, Chicago, Ill.

American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, Sept. 9-11, Hot Springs, Va.

American Hospital Association, Sept. 13-16, Chicago, Ill.

American Academy of Ophthalmology and Oto-Laryngology, Sept. 19-24, New York City.

Ohio Academy of General Practice, Sept. 21-23, Columbus.

American Roentgen Ray Society, Sept. 21-24, Washington, D. C.

The Frank E. Bunts Educational Institute, Cleveland Clinic, Postgraduate Course, Sept. 29-30, Cleveland.

Second Councilor District Meeting, October 1,, Dayton.

American Academy of Pediatrics, Oct. 4-7, Chicago.

Central Association of Obstetricians and Gynecologists, Oct. 6-9, St. Louis, Mo.

Northwestern Ohio Medical Association, Oct. 8, Tiffin.

Academy of Psychosomatic Medicine, Oct. 8-9, New York City.

Ashland County Medical Society Heart Program, Oct. 13, Ashland.

Symposium on the Nutritional Aspects of Blood Formation, Oct. 22, Cincinnati.

American Society of Anesthesiologists, Oct. 25-28, Cincinnati.

Annual Convention of the National Gastroenterological Association and of the American College of Gastroenterology, Oct. 25-27, Washington, D. C.

Sixth Councilor District, Oct. 27, Akron.

The Frank E. Bunts Educational Institute, Cleveland Clinic, Postgraduate Course, Oct. 27-28, Cleveland.

Annual Clinical Congress of American College of Surgeons, Nov. 15-19, Atlantic City, N. J.

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* * *

Rehabilitation Centers in the United States. Contains information submitted by 39 centers in connection with the First National Conference on Rehabilitation Centers. Available on request from the National Society for Crippled Children and Adults, 11 South LaSalle Street, Chicago 3.

* * *

Polio Pointers for Parents—1954. Available to physicians, hospitals and others in the health field for use during the polio epidemic season. A companion poster may also be ordered. Supplies of each may be secured without charge from Hart E. Van Riper, M. D., Medical Director, National Foundation for Infantile Paralysis, 120 Broadway, New York 5.

* * *

Poliomyelitis Vaccine Types 1, 2, and 3. The recommendations of the Vaccine Advisory Committee of the National Foundation for Infantile Paralysis, and a statement of the United States Public Health Service regarding the vaccine's use. Available from the Foundation, 120 Broadway, New York 5.

* * *

The Part the Physician Should Play in Civil Defense Activities. A collection of six articles reprinted from the *Journal of the American Medical Association* which discuss such aspects as organizing for civil defense, medical participation, improvised hospitals, etc. Available free from the Council on National Emergency Medical Service, American Medical Association, 535 North Dearborn St., Chicago 10.

* * *

Proceedings of the Medical Civil Defense Conference. Information on atomic bombing, threat of biological warfare, chemical warfare and psychological warfare discussed at the conference on Medical Civil Defense held in Louisville, Ky., in February. Available free from Council on National Emergency Medical Service, American Medical Association, 535 N. Dearborn St., Chicago 10.

* * *

Why Wait? Published by the American Medical Association. Discusses best way to select a family doctor. For distribution to the public at meetings, county fairs, etc. Available in quantities without charge from the Ohio State Medical Association, 79 E. State Street, Columbus 15.

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Quack. Published by the American Medical Association. Warns the public about quack healers and the dangers of going to them. For distribution in waiting rooms, at public gatherings, fairs, etc. Available in quantities without charge from the Ohio State Medical Association, 79 East State Street, Columbus 15.

Oberlin Team Undertakes Study On Premedical Training

A four-man research team from Oberlin College has undertaken a study which, in the opinion of the sponsoring group, may have widespread influence on premedical training in the United States. The project, to be known as the Study of Preparation for Medical Education in a Liberal Arts College, will take more than a year to complete. It is being supported by a grant of $5,500 from the Commonwealth Fund in New York City.

The purpose of the study is to compare the experiences of students in medical schools as they relate to their undergraduate programs. Part of the project is for the team to visit 25 medical schools where Oberlin graduates have studied in the past decade.

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Recent Opinion of the Attorney General

Following is the syllabus of Opinion 4104 recently given by Attorney General C. William O'Neill:

(1) A board of county commissioners is authorized, under the provisions of Sec. 339.39, R. C., to employ a physician for the treatment of tuberculous patients who are residents of the county, whether or not a clinic is established as authorized in such section, but only the general funds of the county may be expended for such purpose, the special funds derived from tax levies under authority of Sec. 5705.20, R. C., being limited to the support of tuberculosis hospitals and the care, treatment and maintenance of patients actually hospitalized in a tuberculosis institution as pointed out in Opinion No. 3623, Opinions of the Attorney General for 1954, dated March 19, 1954.

(2) Under the provisions of Sec. 3709.22, R. C., a local board of health is under a mandatory duty to "provide for the prompt diagnosis and control of communicable diseases" and in the performance of such duty such board may provide for dispensing drugs and medicines for the treatment of tuberculous patients upon the prescription of physicians employed by the board of county commissioners. Such board of county commissioners have discretionary authority to supply to such board of health the funds necessary to provide such drugs and medicines.

Future A. M. A. Meetings

The 1954 Interim Session of the American Medical Association will be held in Miami, Fla., November 30-December 3.

The 1955 Annual Session will be in Atlantic City, June 6-10.

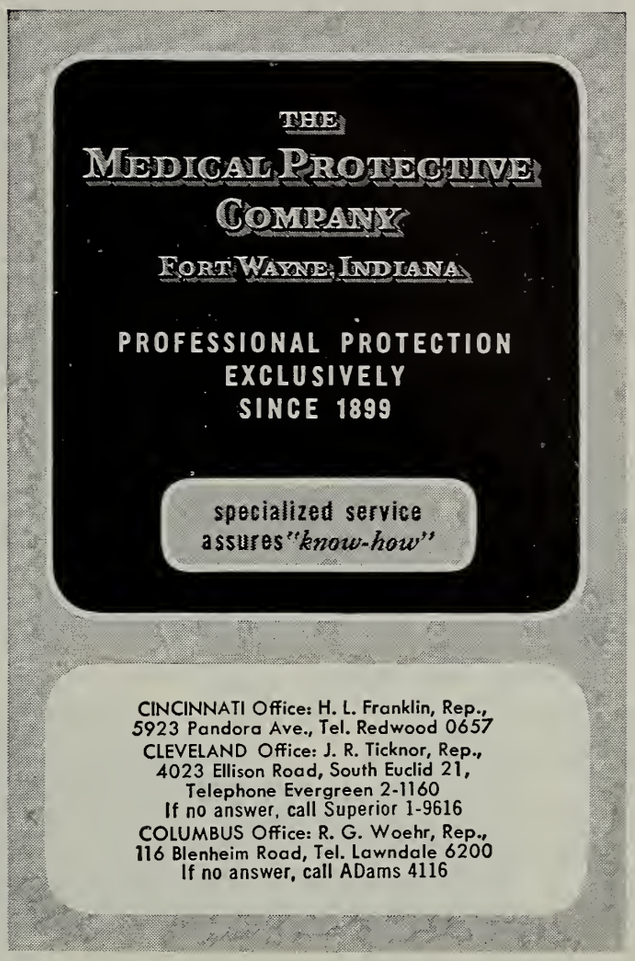
Other future annual sessions have been set as follows: 1956, Chicago (June 11-15); 1957, New York; 1958, San Francisco; 1959, Atlantic City.

Military Medico-Dental Symposium

The Fifth Annual Military-Medico-Dental Symposium will be held at the U. S. Naval Hospital, Philadelphia, Pa., October 18-23. Members of the Ohio State Medical Association are invited.

Registration facilities will be available for Army, Navy and Air Force Reserve Medical Department officers. One retirement point credit is awarded for each day's attendance. Nonreservists will be required to register in order to be admitted.

Communications should be addressed to the District Medical Officer, Fourth Naval District, U. S. Naval Base, Philadelphia 12, Pa.



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GYNECOLOGY—Office & Operative Gynecology, two weeks, Sept. 20. Vaginal Approach to Pelvic Surgery, one week, Sept. 13.

OBSTETRICS—General & Surgical Obstetrics, two weeks, Oct. 4.

MEDICINE—Two Week Course Sept. 27. Electrocardiography & Heart Disease, two weeks, Oct. 11. Gastroenterology, two weeks, Oct. 25. Gastroscopy, one week, Sept. 13.

RADIOLOGY—Diagnostic Course, two weeks, Oct. 4. Clinical Uses of Radio Isotopes, two weeks, Oct. 4.

PEDIATRICS—Clinical Course, two weeks, by appointment. Congenital & Rheumatic Heart Disease in Infants & Children, one week, Oct. 11 and Oct. 18; two weeks, Oct. 11.

UROLOGY—Two-Week Urology Course, Sept. 20. Ten-Day Practical Course in Cystoscopy every two weeks.

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Personal communication (Apr. 12, 1950)

1951 Of 119 patients treated with Azulfidine prior to 1944, 90 patients (75%) were symptom-free or considerably improved when re-examined in 1949.

Svartz, N.: Acta. Med. Scandinav. 141:172, 1951.

1952 In a series of 52 patients with chronic ulcerative colitis 30, or 58%, showed significant improvement after treatment with Azulfidine.

Morrison, L. M.: Gastroenterology 21:133, 1952.

1953 *Morrison says:* "Azopyrine [Azulfidine] . . . has been effective in controlling the disease in approximately two-thirds of patients who had previously failed to respond to standard colitis therapy currently in use."

Morrison, L. M.: Rev. Gastroenterology 20:744 (Oct.) 1953.

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Deaths From Competitive Sports Small In Proportion to Number Involved

Bloody noses, strained muscles, and assorted lumps and contusions are relatively common in competitive sports, but injuries severe enough to cause the death of a participant are quite rare, statisticians of the Metropolitan Life Insurance Company find.

The statisticians, studying the causes of death among the millions of males between the ages of 10 and 29 insured under the company's industrial policies, discovered that less than one in each 300 accidental deaths could be attributed to competitive sports. During the two years under study—1951 and 1952—only 11 deaths in this group resulted from competitive athletics. Baseball and softball accounted for four of these deaths, golf for three, basketball for two, and football and track for one death each.

Information gathered by the statisticians from a wide variety of sources supported the results of the study. For instance, New York City records show that the largest city in the country has averaged only three deaths a year from competitive sports for more than 30 years.

Additional information on this subject may be obtained from the Metropolitan Information Service, 1 Madison Ave., New York City.



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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

The Voyage of The Vega, by James Bird Cutter, M. D., ($3.50. *Comet Press Books, New York, N. Y.)*, is a fascinating autobiographical account of a long life, rich in adventure. Dr. Cutter began his career in medicine as the physician aboard the Portuguese ship, The Vega, in 1895. He returned to Portland and embarked on a distinguished medical career.

Cancer, New Approaches, New Hope, by Boris Sokoloff, ($3.75. *Devin-Adair Company, New York, N. Y.)*. The Director of the Southern Biological Research Laboratories of Florida Southern College, has made an interesting, thoroughly documented, critical review of what we know today about the prevention and treatment of cancer. It is a book that certainly ought to be in every public library, to be used to clear up ignorance and confusion, to dispel fear and undue hopelessness.

Metabolic and Toxic Diseases of The Nervous System, edited by H. Huston Merit, and Clarence C. Hare, ($10.00. *Williams & Wilkins Co., Baltimore 2, Md.)*, is the 1952 proceedings of The Association for Research in Nervous and Mental Diseases. Recent advances in biochemistry have thrown considerable light on the relationship between metabolic defects or toxic agents and disease of the nervous system. This has destroyed our faith in the concept that degenerative diseases were to be explained by an inherent weakness of nervous structures. This Conference was devoted to an attempt to present the known facts concerning metabolic disturbances and toxic substances which are the cause of disease of the nervous system, in an effort to stimulate further investigation.

The Treatment of Barbiturate Poisoning—A Modified Clinical Aspect, by Eric Nilsson, *(Kristianstad 1951, Kristianstad s Boktryckeri AB.)*. That which differentiates the author's treatment from others is, on the one hand, improved care of the air passages with intensive oxygen therapy as though the patient were under anesthetics, and on the other hand, the exclusion of all analeptics in treatment. The author's results—a death rate of a fraction over 1 per cent, as compared with 20 per cent in most series—justifies his kind of treatment and serves to condemn intensive stimulation with analeptics as a principal treatment.

The Doctor's Last Message, a novel by Julius Buscher, ($3.00. *Exposition Press, New York 10, N. Y.)*. The author, himself a Minnesota physician, writes of the life of a doctor in St. Cloud, with the authority of his own experience. It begins with a letter from the doctor which is delivered to his wife after his death. It reveals some of the untold occurrences of his practice, which have a bearing on the lives of the doctor's own family and of his friends. Most of the everyday problems of a physician are met within its pages as the story unfolds.

Montana Medical Association 1879-1953, published by *The Montana Medical Association, Billings, Montana.* This booklet gives a picture of the ever-present hopes, aims, and accomplishments of the medical profession as illustrated by the history of medicine in Montana.

The Pre-Adolescent Exceptional Child, *(The Woods Schools, Langhorne, Pa.)*, is the proceedings of the 35th Conference of the Children's Research Clinic of The Woods Schools. The contents are largely devoted to the management and treatment of the mentally retarded preadolescent child.

A Doctor at Calvary, by Pierre Barbet, M. D., translated by the Earl of Wicklow, ($3.00. *P. J. Kennedy & Sons, New York 7, N. Y.)*. The passion of our Lord Jesus Christ is described by a surgeon. It brings together in one book the results of the author's anatomical experiments, and his archaeological and scriptural researches, as well as his reflections. It is interesting to note how much the author believes we now know about the death of Jesus, about his terrible sufferings, and about how he died, suffering from cramps in all his muscles and from asphyxia.

The History of Nursing, by Bertha S. Dodge, ($3.00. *Little, Brown & Company, Boston 6, Mass.)*. This book attempts to touch upon the highlights of American nursing, past and present. The present is handled as a synthetic metropolis, "Central City," with composite nurses working there. Beginning with the days of Chivalry, and through Florence Nightingale, the Civil War, Dorothy Dix, and Clara Barton, it brings us to the present and then projects us into the future. It is a book that should be placed in the hands of those who might take up the calling, and a challenge to those who have undertaken one of the most gruelling and yet usually the most rewarding of occupations.

The Biochemistry of Clinical Medicine, by William S. Hoffman, M. D., ($12.00. *The Year Book Publishers, Inc., Chicago, Ill.)*. This is designed to clarify that portion of the vast array of recently accumulated information in biochemistry which will help the clinician in the practice of medicine. The author makes the significant admission that our knowledge of the metabolism

of some of the body constituents is still too meager, to allow a complete picture to be drawn of the physiological significance of deviations from the normal. We have to be satisfied with the empiric relations that have been discovered, or to speculate on their possible significance. The book, however, is aimed at the level of the general practitioner, with no more than the usual training in chemistry and physiology. The approach is entirely didactic. The chapters on Diabetes Mellitus, Bright's Disease, Hepatitis, Cirrhosis, and Gout, have been written as completely clinical essays, reflecting the doctor's considerable clinical experience. The other chapters are briefer, but are also well done. Special attention has been paid throughout the book to the principles of treatment based upon the restoration of the normal.

Pharmacology and Therapeutics in Nursing, by Marion S. Dooley, M. D., and Josephine Rappaport, R. N., ($4.50. *McGraw-Hill Book Co., New York 18, N. Y.)*, brings up to date the many new drugs and gives the recent advances in drug therapy for nurses.

Atlas of Exfoliative Cytology, by George N. Papanicolaou, M. D., ($18.00. For *Commonwealth Fund by Harvard University Press, Cambridge 38, Mass.)*. This complete atlas will be a great help to many. These studies are of increasing importance in the study of the physiology of the female generative organs and in the detection of cancer.

The Origin of Life, by Aleksandr I. Oparin, Translated by Sergius Morgulis, ($1.70 paper, $3.50 cloth. *Dover Publications, Inc., New York 19, N. Y.)*. Rejecting theories of eternal life, spontaneous generation and dissemination by spores carried by cosmic dust, Oparin suggests that the origin of life was preceded by a gradual and long evolution of organic substance of the carbon and nitrogen compounds upon which organisms depend for their very existence.

Disorders of the Circulatory System, edited by Robert L. Craig, M. D., for the New York Academy of Medicine, ($5.50. *The Macmillan Co., New York 11, N. Y.)*. A report of the 24th Graduate Fortnight. The role of connective tissue, contraction of the muscles, lipid metabolism, diet and atherosclerosis, coronary disease, arrhythmias, physiology, mitral stenosis, surgery and circulatory response to like situations and others, are all subjects treated in detail by experts in this book.

Thoracic Surgery, by Richard H. Sweet, M. D., ($10.00. Second Edition. *W. B. Saunders Co., Philadelphia 5, Pa.)*. It is the author's concept that any well qualified surgeon can acquire with relative ease a satisfactory proficiency in thoracic surgery by employing the technics which he describes in this work. In spite of the fact that the book appeared in 1951, its favorable reception has been such that this edition was made necessary by it. The present volume provides descriptions of certain new technics which have gained wide acceptance in the meantime. The revision has been complete.

Clinical Orthoptic Procedure, by William Smith, O. D., ($10.00. Second Edition. *C. V. Mosby Co., St. Louis 3, Mo.)*. This is an orderly and systematically arranged compilation of the material based entirely upon recognized methods and clinical results written by the instructor in the Massachusetts College of Optometry.

The Doctor's Wyoming Children: A Family Chronical, by Woods Hocker Manley, ($3.50. *The Exposition Press, New York 10, N. Y.)*. Setting out from Missouri on the comparatively new Union Pacific Railroad, Dr. Hocker was headed for California to establish himself in practice. While crossing the mountain wilderness of Wyoming territory the train stopped twenty minutes in Evanston. The Doctor was asked to see a child desperatelv ill with pneumonia. He stayed and let the train go on. The upshot of it was that he settled down in the town and spent a long and colorful life caring for the people of the town. This is the story as told by his distinguished daughter.

Reconstructive Surgery of The Eyelids, by Wendell L. Hughes, M. D., ($8.50. Second Edition. *C. V. Mosby Co., St. Louis 3, Mo.)*. Two hundred and fifty large pages devoted to the care of this important operation in peacetime but more especially in war.

A Doctor Talks to Women, by Samuel Raynor Meaker, M. D., ($3.95. *Simon & Schuster, Inc., New York 20, N. Y.)*. A well-known authority on fertility and female reproduction tells intelligent women what they want to know and need as well to know. An informative, interesting, and helpful book which can be made to serve a most useful purpose with many if not all of a physician's female patients.

Wonder Drugs, by Donald G. Cooley, ($2.75. *Franklin Watts, Inc., 699 Madison Ave., New York, N. Y.)*. The absorbing story of the drugs which make up fully 90 per cent of the current prescriptions, none of which could have been filled 20 years ago. The author, a well-known science writer, explains what is known about these miracle drugs—sulfas, antibiotics, vitamins, hormones, as well as a variety of new treatment.

Illustrated Review of Fracture Treatment, by Frederick Lee Liebolt, M. D., ($4.00. Fifth Edition. *Lange Medical Publications, Los Altos, Calif.)*. This volume illustrates and discusses briefly and systematically the principal features concerned in the diagnosis and treatment of fractures.

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Vol. 50 October, 1954 No. 10

JONATHAN FORMAN, M. D., *Editor*

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Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Physical Medicine and Rehabilitation For Chronic Illness*

FRANK H. KRUSEN, M. D.

WHEN the average physician faces the problem of the physical, mental and social rehabilitation of patients who are chronically ill or seriously disabled, naturally he is prone to ask certain questions. These questions might well include the following ones:

1. What is the present situation regarding chronic illness in the United States?
2. What is physical medicine and rehabilitation?
3. Is chronic illness increasing?
4. Should the general employment of physical medicine and rehabilitation for chronic illness be expanded?
5. What can the average physican do about rehabilitation of the chronically ill?
6. What are the results which can be expected from well-organized efforts at physical, mental, social and vocational rehabilitation of the chronically ill?

Let us consider these questions in order.

WHAT IS THE PRESENT SITUATION REGARDING CHRONIC ILLNESS IN THE UNITED STATES?

Because of our preoccupation with the enormously difficult problems encountered in the management of acute illness and the saving of lives, we physicians and also the public at large have tended to put off and to neglect our duties in relation to the rehabilitation of chronically ill and seriously disabled persons. Now it is essential for us to support the challenging new concepts of dynamic physical, mental and social rehabilitation and to abandon the traditional, passive acceptance and neglect of the increasingly serious problems of chronic illness and extensive disability.

Since 1900 the medical profession has made extraordinary progress in the management of acute illness and in the reduction of mortality in our country. Now we should be turning every effort toward achieving similar progress in the management of chronic illness. Many of the infectious diseases, including typhoid fever and the principal communicable diseases of childhood (measles, scarlet fever, whooping cough and diphtheria), have been all but wiped out as causes of death. The death rate in tuberculosis has been diminished by about 90 per cent and the record for pneumonia is almost equally impressive.

These remarkable advances in the treatment

*Presented before a general session at the Annual Meeting of the Ohio State Medical Association, Columbus, Ohio, April 13 to 15, 1954.

The Author

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of acute illness have produced for physicians a wholly new group of problems in relation to chronic illness. Medicine's achievements in postponing death have produced the necessity for development of new approaches which will extend the physical treatment and rehabilitation of an ever increasing number of chronically ill and seriously disabled persons. Medical practitioners have saved many chronically ill and seriously injured persons from death but there can be worse things than death.

THE RESPONSIBILITY OF THE PHYSICIAN

Every physician must be a humanitarian and it is often more humane to save a chronically ill or seriously disabled person from years of dependency than it is to save his life. Each time that the skilled surgeon saves the life of a patient who might previously have died of extensive and seriously crippling injuries and each time that a clever medical practitioner prevents the death of an extensively paralyzed patient during the acute phase of poliomyelitis, a triumph over death is achieved. But at the same time, these physicians have created for themselves a new problem in management of chronic disability and in providing proper facilities for the physical, mental and social rehabilitation of a living but extensively disabled chronically ill patient.

One of the major responsibilities of the modern physician is to restore such persons to self-respecting citizenship by every possible means.

PRINCIPLES INVOLVED IN MEETING PROBLEM OF CHRONIC ILLNESS

A recent survey[1] has revealed that three major principles should be followed to meet the challenge presented by the major problem of chronic illness.

(1) "The first principle is that the care of the chronically ill must be brought up to the standard of the care given to persons with acute illness. Shoddy facilities that are still being used for the care of the chronically ill and the shabby attitudes that still characterize a part of the general public, and a rearguard of professional groups, can no longer be tolerated."

(2) The second principle is that "the care of the chronically ill is inseparable from general medical care, that one weaves through the other. Therefore, facilities and services for the chronically ill should be planned in close administrative, professional and geographic affiliation with general hospitals and where feasible, with medical schools."

(3) The third principle is that "the needs of the chronically ill are so varied that facilities and services must be planned for the patients to move easily from home to hospital to nursing home and vice versa."

I believe that we can all subscribe without reservation to all three of these principles. It has been said,[2] "There is an urgent need for the promotion of an educational program in the field of chronic illness with particular emphasis on the value of rehabilitation and the need for additional rehabilitation facilities."

At the first conference of the Commission on Chronic Illness,[3] prevention was made the cornerstone of any future program. It was recommended that attempts should be made to launch vigorous attacks on the chronic diseases in the hope that these attacks would be as successful as were the efforts of the past few decades to reduce acute illness. However, there are certain chronic diseases that cannot be prevented. Certain types of chronic disease are just as inevitable as death itself and, like death, they cannot be prevented; they can merely be postponed. It was pleasing, therefore, to see that at its second conference, the Commission on Chronic Illness turned its attention to the care of the chronically ill. Care and rehabilitation of the chronically ill are just as important as prevention because, in many instances of chronic disease, we must devote our major attention to the physical, mental and social rehabilitation of the patient. We must realize that we must often assist our patients to live, with the greatest possible happiness and productivity, despite the fact that they suffer from certain inevitable chronic illnesses.

OBSERVATIONS ON THE CLINICAL AND PATHOLOGIC CHANGES IN OLDER PERSONS

Recently Monroe,[4] in a scholarly clinical and pathologic study of 7,941 persons more than 61 years of age, made certain very significant observations. One was that with regard to hospital admissions, "in 1913 one in every 16 admissions was an individual over 61 while in 1943, one in every five admissions was over 61." Thus, in a period of 30 years, there was an increase of more than 200 per cent in the proportion of hospital admissions represented by older persons. Monroe observed that heredity appears to be a factor in longevity. Nearly half of the parents of patients who lived more than 60 years had themselves lived for periods ranging from 60 to 80 years and a little more than one fifth of these parents had lived for more than 80 years.

It was interesting to note that more than a third of these patients exhibited a psychoneurotic reaction. Hemiplegia, old or recent, was found in 516 patients. Monroe concluded that hypertension is found so generally in old age that it can scarcely be considered abnormal of itself. It is perfectly compatible with a long life and an active one. Heart disease is the most common disease other than hypertrophic arthritis in old age. Old people with normal hearts are becoming fewer.

Gallstones were found in no less than 1,010 of the 7,941 patients; a medical mortality rate of 17.8 per cent among patients having gallstones

well exceeded the surgical mortality rate. Therefore, Monroe urged that patients having gallstones undergo surgical treatment as soon after the diagnosis is established as possible. Hypertrophic arthritis was found in all persons more than 61 years of age. Neoplastic disease was found in 1,110 patients or 13.9 per cent of the series.

It is obvious that many such chronic diseases cannot be prevented entirely and that we must turn our major attention to the rehabilitation of patients having chronic illness and to training them to make the most of what they have left. Physical therapeutic and rehabilitative procedures play a very important part in the management of many of these chronic diseases and serious disabilities. At this point one may ask for definitions and for a clearer description of physical medicine and rehabilitation.

WHAT IS PHYSICAL MEDICINE AND REHABILITATION?

Physical medicine has been defined as the employment of various physical agents and devices, therapeutic exercises, corrective procedures, occupational therapy and physical rehabilitation in the diagnosis and treatment of diseases and injuries.

It has been stated[5] that "formerly the objective of physical medicine was limited to the restoration of function of injured parts. The experience of the war showed that usually the whole man is affected adversely when one part of his body is disabled for more than a brief period. This adverse effect often is mental as well as physical. Consequently, the field of physical medicine was expanded into rehabilitation."

Rehabilitation has been defined[1] as "the restoration through personal health services of handicapped individuals to the fullest physical, mental, social and economic usefulness of which they are capable, including ordinary treatment, and treatment in special rehabilitation centers." In recent years, rehabilitation has come to be regarded as a creative procedure in which the physical, mental and social abilities, which the chronically ill patient still possesses, are developed to the greatest possible degree of effectiveness. It includes the co-operative effort of various medical specialists, technical workers and vocational counsellors to improve the physical, mental and vocational abilities of persons who are chronically ill, with the objective of preserving their ability to live happily and productively on the same level and with the same opportunities as their neighbors.[6]

It has been said[7] that the composite science of rehabilitation includes the use of "medicine and surgery, therapy, psychology and psychiatry, patience, kindness, friendly understanding, and vocational training in efforts to help the physically handicapped re-educate themselves to live and work and love by enlisting their minds, hearts and bodies."

One may next inquire as to whether chronic illness is increasing sufficiently to warrant extensive efforts to expand these plans for a group approach to the physical restoration and rehabilitation of the chronically ill.

IS CHRONIC ILLNESS INCREASING?

Recently it has been shown[1] that "great backlogs of need have accumulated, and are being increased daily because insufficient attention has been paid to prevention of chronic disease and to rehabilitation of persons already disabled . . . the total number of individuals with some sort of known physical or mental impairment has been estimated as about 28 million." Almost 4,000,000 of these persons are invalids or are disabled for long periods.

Chronic illness has become the major medical problem of the day and because it is increasing it deserves to be considered by the average physician as being as important as, if not more important than, the problem of acute illness. Because of the great success of the medical profession in prevention and treatment of acute diseases, the life span of the average person has extended from 49 years in 1900 to approximately 70 years today.

During the period between 1900 and 1950, the number of persons more than 65 years of age in the United States increased 297 per cent,[8] and although, according to the social security records, the average age of the American citizen at retirement is about 69 years, people who reach that age still have an expectation of life of about 12 years.[9] Inevitably, a high percentage of the rapidly increasing numbers of older persons in this country must succumb to certain chronic illnesses and inevitably the medical profession must give more and more attention to these chronic illnesses and disabilities.

Despite the remarkable success of the medical profession in prolonging life until old age is reached, our failure to cope adequately with chronic illness, once these enormous numbers of persons have reached old age, is indicated by the fact that the life span from then on has not been lengthened notably. For example, the white man aged 70, in 1950 could expect to live only about 9½ months longer than he could have in 1900.[8]

In 1860 there were only 860,000 people in America who were more than 65 years of age. By 1950 the number had risen to 11,270,000 and by 1980 there will be 22,000,000. Thus, in 90 years, the number of older people in the United States, who are prone to become chronically ill, has increased 13-fold and in another 30 years it will have increased 25-fold. So the answer is: "Yes, chronic illness is increasing enormously."

One may then inquire concerning means of cop-

ing with the problem and thus lead to the next question.

SHOULD THE GENERAL EMPLOYMENT OF PHYSICAL MEDICINE AND REHABILITATION FOR CHRONIC ILLNESS BE EXPANDED?

President Eisenhower,[10] in his recent special message to Congress on the nation's health problems, said, "There are two million disabled persons who could be rehabilitated and, thus, returned to productive work. Only 60,000 now are being returned each year. Our goal should be 70,000 in 1955 . . . for 1956, 100,000 . . . in 1956, the states should begin to contribute to the cost of rehabilitating these additional persons. By 1959 with . . . states . . . sharing with the federal government, we should reach the goal of 200,000."

In order to reach this goal of physical, social and vocational rehabilitation of 200,000 chronically ill or disabled persons a year which has been set by President Eisenhower, we physicians and our associates in ancillary fields must perform a miracle of humanitarian endeavor within the next five years. And even then, we shall not have achieved the ideal of making every effort to rehabilitate each person who becomes chronically ill or disabled because, in addition to the great backlog of chronically ill or disabled persons previously mentioned, it is estimated that each year some 250,000 persons become disabled by chronic illness or serious injury.

It is very important to remember that chronic disease is the major cause of the handicapping of our patients. Chronic disease accounts for 88 per cent of all cases which could benefit from rehabilitation. Congenital conditions account for 2 per cent, occupational accidents and injuries for 5 per cent and other accidents, including those in the home and on the highway, account for another 5 per cent but disease supplies the steady backlog of incapacitation.[1] Certainly then, we should expand our efforts to rehabilitate those who are chronically ill.

WHAT CAN THE AVERAGE PHYSICIAN DO ABOUT REHABILITATION OF THE CHRONICALLY ILL?

Every physician must abandon, and strive to have his associates and patients abandon, an attitude of passive acceptance and neglect of chronic illness and to substitute an attitude of optimism and vigorous dynamic rehabilitation of those who are chronically ill or disabled.

Physical medicine and rehabilitation of the chronically ill is a subject in which every physician should be interested but at the same time, we should also have specialists in this field. Simply because a physician specializes in this field, he cannot be considered, and I am certain that he does not want to be considered, as arrogating rehabilitation to himself. The specialist in this field, now commonly called a physiatrist, does want to see physical medicine and rehabilitation carried on in close liaison with, and preferably as part of, the community hospital. Furthermore, he does want to see that close medical supervision of the lay workers in rehabilitation is exercised by some interested physician, who need not, and in fact cannot, always be a specialist in physical medicine and rehabilitation.

It is amusing and at the same time disturbing to find how many groups of physicians who previously paid little or no attention to the elaborate modern methods for rehabilitation of the sick until they were brought to the fore by the new specialty of physical medicine and rehabilitation, now claim that they are the groups who should *really* be doing rehabilitation.

In one sense, this is excellent because it is true that all physicians *should* be contributing to the development of rehabilitation procedures and participating in joint efforts to rehabilitate the chronically ill and disabled. In another sense, however, if prejudice leads to hampering of the growth of this lusty infant among medical specialties, by jealous and unfair attempts to wrest its name away, then the work of a dedicated group of specialists, who want only to share their efforts with every general practitioner and with every other specialist, may be seriously damaged. Some group of physicians must specialize primarily in the teaching, research and development of physical medicine and rehabilitation, just as some groups of physicians must specialize in public health and in psychiatry, if these phases of medicine are to be taught and practiced adequately in our medical centers.

To claim, as certain incompletely informed physicians have done, that specialists in physical medicine and rehabilitation have attempted to arrogate rehabilitation to themselves is as illogical as it would be to claim that public health officers and psychiatrists have attempted to arrogate the entire practice of public health or psychiatry to themselves.

Every physician must constantly develop public health practices and utilize psychiatry in his daily work and he should also be giving equal attention to the new developments in rehabilitation. Physicians and laymen alike should support the development of the fascinatingly interesting new phase of medicine, known as physical medicine and rehabilitation, in the management of patients handicapped with chronic illness or injury. More extensive understanding and general employment of physical, mental and social rehabilitation of the chronically ill is of the utmost importance; therefore, we cannot now continue the previous national tendency to accept passively and to avoid concern with the rapidly growing problem of chronic illness.

PROPER CONCEPTS OF REHABILITATION FOR CERTAIN COMMON CHRONIC DISEASES

One of the first things that the average physician should do about chronic illness is to de-

velop, in conjunction with his own practice, proper concepts of the physical, mental and social rehabilitation of patients having such common chronic diseases as hemiplegia, osteoarthritis and heart disease. There are more than a million hemiplegics in this country and naturally the overwhelming majority of hemiplegics belongs to the older age group.[11] Although the rehabilitation of hemiplegics is often difficult, frequently their condition can be considerably improved. About 80 per cent of them can be retrained for ambulation successfully.

Similarly, one may consider, for example, the serious disability frequently resulting from osteoarthritis of the knees in older, obese persons. In such patients a simple program in which the weight is reduced and radiant heat is applied by means of a simple homemade baker, followed by massage given by a carefully instructed member of the family, will bring considerable relief. If, then, the patient is provided with elastic knee supports to be used while standing or walking and told to avoid sudden twists or turns of the knees, the relief of symptoms is often striking. Finally, if, in private practice, the physician understands the rehabilitation phases of the management of heart disease, he can as a rule maintain even the patient who has serious cardiac disease independent and employed, at least in light work.

The second thing that the average physician can do about this problem is to support the development of good centers of physical medicine and rehabilitation in our community hospitals. I have often stressed the point that the proper management of chronic illness can best be achieved by the proper co-ordination of private practice of medicine with centers of physical medicine and rehabilitation (conducted by physicians) in our community hospitals and with vocational rehabilitation (conducted by social workers and educators) in voluntary agencies and state departments of welfare and education.

THE NEED FOR ADEQUATE FACILITIES FOR THE CHRONICALLY ILL IN OUR COMMUNITY HOSPITALS

Until recently many community hospitals have been reluctant to provide an adequate number of beds for care of the chronically ill and even though they may have departments of physical medicine and rehabilitation, they do not always provide the bed services for the rehabilitation of the chronically ill which are now considered highly desirable.

The department of physical medicine and rehabilitation in the general hospital should have its own bed service, not for the domiciliary care and vegetation of a group of patients with permanent disability, but for the vigorous, dynamic restoration of such chronically ill persons to the fullest possible physical, mental and social productivity and usefulness. It is now recommended that the average general hospital of 200 beds or more should set aside 20 per cent of the beds for the care of chronically ill patients.[1]

Dr. Walter B. Martin,[12] president-elect of the American Medical Association, recently told a committee of the national House of Representatives, "In future construction of health facilities, particular attention should be given to institutions for the chronically ill. We believe these should be constructed contiguous to or in connection with general hospitals." Similarly, Dr. George F. Lull,[13] general manager of the American Medical Association, in a letter addressed to the same committee of the House, mentioned as a primary recommendation "that facilities for the chronically ill and impaired should be part of or near a conventional hospital." Likewise, the Minnesota Commission on Aging,[14] following a recent survey, recommended an increase in the number of hospitals for the chronically ill and disabled and recommended that these institutions be affiliated with general hospitals. So let us endeavor to increase the facilities for the rehabilitation of the chronically ill in all our general and community hospitals.

VOCATIONAL REHABILITATION OF THE CHRONICALLY ILL

The next step for the average physician to take is to become familiar with the activities of the Office of Vocational Rehabilitation in his own state so that when he has completed the physical and mental rehabilitation of his chronically ill patient, he may seek the aid of vocational counsellors and of vocational training programs to rehabilitate the patient, when necessary, vocationally.

Finally, the physician should support the programs for employment of the handicapped, such as those being fostered by the President's Committee on Employment of the Handicapped. Last fall President Eisenhower[15] mentioned that there are many committees which carry the title of "the President's Committee" but he said "there is none that engages the interest of my heart, or of which I am prouder, than this one."

If we are to be successful in restoring the chronically ill to self-sufficiency and happiness, the physical and mental rehabilitation provided by physicians and the vocational rehabilitation provided by social workers must be followed by efforts to maintain high levels of employment for the chronically ill and aged. It will be futile to help handicapped persons across the long valley from disability to employability unless they can be given suitable work. Even though the person with chronic illness is disabled in so far as one function of the body is concerned, usually he can still perform well in many types of activity. Many persons with minor or even major chronic

diseases or disabilities are still ready, willing and able to work.

There is one final question which can be asked.

WHAT RESULTS CAN BE EXPECTED FROM WELL-ORGANIZED EFFORTS AT PHYSICAL, MENTAL, SOCIAL AND VOCATIONAL REHABILITATION OF THE CHRONICALLY ILL?

Properly organized over-all programs for the rehabilitation of the chronically ill have been shown to produce enormous benefits to sick and disabled persons as well as to the whole community. Many examples can be cited but one example will show what can be done. It was reported[1] that in West Virginia during 1951 "the disabled members of 376 families receiving public assistance were rehabilitated. These families were receiving annually about $225,000 in assistance payments. It cost less than this amount to rehabilitate them. Now they are not only off the public rolls but they are earning about $500,000 a year." Thus, not only the person who is chronically ill, but also the community is benefitted.

However, although the economic argument for the establishment of rehabilitation programs is a strong one, the real goal is not the saving of dollars and cents. "The real goal is human values. Saving life and enabling it to do the heretofore impossible, requires depths of courage and brings out new wellsprings of satisfaction. Everyone is heartened by what the handicapped can do in the face of really great difficulties. In performing miracles of adjustment, they help keep others from succumbing to the small and trivial things of life."[1]

CONCLUSIONS

I have presented six questions regarding physical medicine and rehabilitation for the chronically ill and then I have endeavored to give you a suitable answer for each of them. If we can achieve in the next 50 years as much progress in the management of chronic illness as we have achieved in the past 50 years in the management of acute illness we shall have served the disabled of this nation well. In our rapidly aging population an increasing amount of chronic illness is inevitable. Physicians must help all chronically disabled persons to bridge the gap between the despair of unemployment and the joy of useful occupation.

As we progress toward new heights of achievement in medical practice it is essential for us as physicians to transcend a mere concern for the saving of life and to battle for the closest possible approach to health and productivity for each patient no matter how serious his illness may be, no matter how old he is and no matter how severely he is handicapped.

Today every physician might well adopt the slogan of the Gerontological Society,[8] which is "to add life to years, not just years to life." During the next half century chronic illness and disability will be the major problem of all health workers. We must join together unselfishly in providing physical, mental, social and vocational rehabilitation, as well as employment, for literally millions of our fellow citizens who are hoping against hope that we can bring them useful lives instead of hopeless ones.

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Infections Caused by Organisms Previously Unknown

In addition to these organisms that have previously been sensitive and are now resistant (to the action of one or more of the antibiotics), we are also becoming increasingly familiar with diseases caused by organisms which were previously almost unknown in medicine. Most important of these are the pigment-producing gram-negative bacilli of the pseudomonas group. These now occur in many situations, particularly as infectious agents in all sorts of injuries and wounds which have been exposed to the external environment. They are also a common cause of pulmonary infection in antibiotic-treated patients.

In addition to these, we are seeing more and more infections by organisms which were completely unknown ten years ago, and without detailing them at the present time, they involve a wide variety of gram-negative bacilli and unusually varied types of micrococci.—Lowell A. Rantz, M. D., San Francisco: *Nebraska State M. J.*, 39:123, April, 1954.

Civilian Hospitals as Rehabilitation Centers

RALPH E. WORDEN, M. D.

THE rehabilitation of the disabled is now everybody's business. It is anticipated that the 1954 crop of the new rehabilitation centers will be bigger and better than the 1953 crop.

As you know, there are many types of rehabilitation centers. The type depends somewhat upon the services offered which can number from one to dozens. The question has arisen as to whether or not a center should be called a rehabilitation center if it provides only one or two rehabilitation services.

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DEFINITION

The National Conference on Rehabilitation Centers offers the following definition of a rehabilitation center: "A rehabilitation center is a facility which assumes responsibility for evaluating the needs and capacities of disabled persons and for providing appropriate individualized services of a medical, psycho-social and vocational nature. The services are substantial and intensive and are integrated with each other and with other services in the community."

Let us examine this definition more closely. First, "A rehabilitation center is a facility." At the present time most of the rehabilitation centers are either in a hospital, in a school, in the facilities of a community agency or exist as an independent institution and are usually located in a large metropolitan area.

A majority of the larger rehabilitation centers are located in hospitals of the armed forces or Veterans Administration. Planning and money have made these facilities the envy of civilian hospital administrators. However, when we examine the next part of the definition, namely, "a facility that assumes responsibility for evaluating the needs and capacities of disabled persons," we find that it may be possible for the civilian hospital to provide service as good as or better than the military hospital.

For a rehabilitation center to have available in one facility all the rehabilitation services that the disabled individuals in a community might need would be physically impossible, but for a center to assume the responsibility for evaluating the needs of these patients and seeing that those needs are provided is a possibility. A civilian hospital can provide appropriate individualized services that will include "medical, psycho-social and vocational" services.

PREVENTIVE MEDICINE

Whatever the cause of the disability the patient is usually hospitalized sooner or later. As the disabled patient filters through the hospital, if that hospital does not have rehabilitation facilities, the greatest opportunity to do the most good for that patient will be lost.

It is discouraging to have to report that even in those civilian hospitals where rehabilitation facilities exist, they are used by only a very small percentage of the staff physicians. The reason for this is partly due to the fact that the staff physicians do not appreciate what can be done in the field of rehabilitation. This appreciation will come in time.

Another reason I think is due to the fact that rehabilitation is considered by physicians, including physiatrists, as the third phase of medicine. Too often the delay is so long before rehabilitation is considered that the individual's funds are exhausted and the patient must be discharged from the hospital although still severely disabled.

Actually, rehabilitation should not be thought of as the third phase of medicine. If one is to obtain the best results, the rehabilitation process must start before soft tissues have become permanently shortened, joints have become ankylosed, decubitus ulcers have developed, renal calculi have formed, mental depression has occurred, an attitude of defeatism has developed, family and social complications interfere and before funds have been exhausted. Therefore, rehabilitation is as much the first phase, or preventive medicine as it is the third phase, or convalescence.

CASE HISTORY

Let us take John Doe through the rehabilitation process. He is a 45 year old man who suffered a cerebrovascular accident. He is a man who is going to need all three areas of rehabilitation, namely, medical, psycho-social and vocational. He was seen in the home by a general practitioner who sent him immediately to the hospital consultants. This physician, realizing the need for early physical activity, referred the patient within a few days to the department of physical medi-

Presented before the section on physical medicine at the Annual Meeting of the Ohio State Medical Association, Columbus, Ohio, April 14, 1954.

cine and rehabilitation. The physiatrist evaluated the patient and supervised the physical therapy and occupational therapy, modifying the treatment as the patient progressed. The patient was soon standing and walking. A speech therapist worked with this man approximately one hour three times a week to help answer the problem of aphasia. A small light cock-up splint was ordered for the wrist-drop that persisted in the left wrist and a short leg brace was ordered for the persistent foot-drop in the left foot. Recreation was provided giving him the pleasure of adult socialization.

REHABILITATION DIAGNOSIS

We all know how important a complete diagnosis is in the treatment of the patient. In Mr. Doe's case the local physician had made the correct diagnosis, the lesion was located, the physical disability was evaluated and, the speech therapist had been able to diagnose the type of speech problem. However, the total rehabilitation diagnosis was not nearly complete. We needed much more information on this patient.

This man was a laborer and earned his money by using both hands. He had no specialized skill or trade. He had a family with two small children and although he had hospitalization insurance, he had no savings. Here we see the need for early psycho-social and vocational evaluation. Personal counseling is a recommended procedure which can be done by the hospital medical social worker or preferably by a counselor who is a permanent member of the staff of the hospital rehabilitation team. If this counselor is not trained to provide psychometric service, then these services must be obtained either by a hospital staff psychologist or from services provided in the community. These services in our community are available not only on the university campus but in the Ohio State Employment Service, the Bureau of Vocational Rehabilitation and psychologists in private practice.

Psychiatric services may very well be necessary before this man and his family have adjusted to his disability. We have found that the psychiatrist must be a member of the rehabilitation team so that the staff can count on regular and follow-up visits.

To help answer the financial problems, work was found for the wife on a part-time basis while her children were in school.

Even before John Doe became physically independent, his vocational counselor had discussed with his former employer the possibilities of what type of job may be available for him. By the time he was physically independent the counselor had planned the patient's prevocational experience. Some information on work tolerance and skills were offered through the occupational therapist in the hospital. Arrangements were made for transitional employment in a sheltered workshop. In other cases the patient can return to his own industrial plant to help determine industrial fitness, or perhaps some vocational training might be indicated. In this case Mr. Doe started by running an elevator and later as his hand and leg improved he became a guard at one of the gates of the industrial plant.

By the new definition a center provides an "intensive and substantial" integrated rehabilitation service. This means the patient receives more than one-half to one hour of treatment two or three times a week. He receives more than a call from the social and vocational counselor once or twice a month. If tolerated, a patient will benefit most from a 4 to 8 hour a day program.

The services must be focused and refocused on the changing needs of the patient. By integrating these various services in the center itself is not enough. The services in a center must be related to the services available in the entire community.

IN-PATIENT SERVICE

What are the advantages of having in-patient rehabilitation services located in a hospital? It increases the number and types of patients that can be benefitted. Many of the severely disabled patients need prolonged definitive medical care. A few examples are the hemiplegic, paraplegic, quadriplegic, burned patient, amputee, and arthritic. If these patients must wait until definitive medical care is complete before rehabilitation is started valuable time is lost. Indeed many unfortunately discover that after waiting for this prolonged period it is now too late.

Physicians in the smaller communities might argue: "Why not send the patient to one of the big centers already established in the city, or if the patient is a veteran, to a V. A. Rehabilitation Center. If this is done the patient is constantly saying to himself, "I should be home with my family. What is happening at home?" Thus unnecessary anxieties may develop. In addition the family is lost as part of the rehabilitation team.

By deferring the development of a rehabilitation center locally the chance to educate the local citizens is lost. A rehabilitation center needs the support of not only the medical profession but the public. They must be given the chance to participate in its development and to gain the deep personal satisfaction in learning to understand and appreciate what rehabilitation is all about.

If local civilian hospitals are willing to take the initiative in evaluating the needs and capacities of the disabled person and to see that he is provided with appropriate individualized services of an all inclusive nature, then three of the most important problems of rehabilitation will be solved. These are: the best location of the rehabilitation center, facilities to meet the needs

of the greatest number of the disabled, and the opportunity to educate the medical staff and the public.

* * *

Discussion of Dr. Worden's Paper

By KEITH C. KEELER, M.D., Akron, Ohio

DR. WORDEN'S concise outline of this popular idea of team approach in physical and vocational rehabilitation of disabled persons has been expertly presented by an expert.

I should like to emphasize that the team concept in a community rehabilitation program implies the community becomes the team. On the medical side of the community it means not only cooperation but actual participation by the medicial Society and its members, through the Advisory Committee of the Medical Society and through the use of members as consultants on a rotating basis. Though the rehabilitation center may be located in a hospital of the community, its activities embrace the community. Further, a dynamic rehabilitation program in a hospital also should be incorporated in the rotational schedule of its interns and residents.

Again, Dr. Worden spoke of psycho-social requirements of a complete rehabilitation program. Resources existing in most communities may well fit into this larger service. The team concept has tended to draw social agencies into a larger sphere of action. That is to say, the Family Service agencies may now turn to the rehabilitation center for help in restoring stability to a family which has been torn apart by factors surrounding chronic illness in the family. Or a physician and the rehabilitation center may call upon the services of the Child Guidance Bureau in order to prepare an emotionally disturbed young polio victim for school. Subsequently, the Board of Special Education, the Polio Society, suddenly find that no one agency can complete the job on its own. I repeat, the concept of a community rehabilitation center, whether in a local hospital or separate from it, may help to dispel competition for existence among social agencies and foster a realistic, modernized version of "one for all, and all for one."

Dr. Worden, in Akron we think a rehabilitation center separate from a hospital has certain advantages too.

Drinking and Driving

In those who had been drinking beer, there was a deterioration in driving. Instead of improving 20 per cent (as noted with the control group) they fell off 18.6 per cent.

In those who were drinking whiskey, there was a decrease in driving ability and skill of 32.7 per cent.—Lewis P. Gundry, M. D., Baltimore: *Maryland State M. J.*, 3:293, June 1954.

KEEPING UP WITH MEDICINE

• IT IS REPORTED that during the past 10 years, 101 children from areas in rural New England have been brought into Vermont hospitals, after swallowing or aspirating kerosene left carelessly within reach.

* * *

• MORE exercise, less Insulin.

* * *

• AFTER DEATH, the body begins to putrefy owing to the activity of millions of bacteria, which find the tissues excellent foodstuff. This sharp contrast between freedom from bacteria during life and their rapid multiplication in our tissues after death indicates that the living body is constantly active in the destruction of millions of microbes every day.

* * *

• FREEDOM from microbes is maintained in life through a comprehensive and very active system of defense. All programs for the drug therapy of infection, therefore, should cooperate with defense mechanisms of the human body.

* * *

• BACTERIA possess the power of adapting themselves to new conditions in their environment. When the poison acts by interfering with the microbial nutrition, the organism may adapt itself by altering its mode of nutrition.

* * *

• CHEMOTHERAPY is a double-edged therapeutic tool. It may give rise to toxic effects, or sensitize the patient so that he is intoxicated by a later treatment. It may also enhance the virulence of a bacterium or promote drug-resistance in microbes.

* * *

• IN THE NOSE there are streams of mucus which move quite rapidly. This mechanism is highly effective in removing dust particles. Otherwise our air-passages would become gummed up in the dirty atmosphere of smoke-laden air of the modern industrial cities.

* * *

• PERHAPS one of the most dangerous organisms harbored by our noses these days is penicillin-resistant *Staphylococcus aureus*. Nasal carriers of these organisms are not infrequently responsible for the spread of antibiotic resistant organisms in swimming pools and public places, including hospitals.

* * *

• INTERESTINGLY enough it has been shown that the mucus in the bronchi can prevent the agglutination of red blood cells by the influenza virus by apparently interfering with the mucus splitting enzyme. In this way the mucus layer may, by reason of its "mucoid inhibitors," prevent the initial union of the virus with the cells of the mucosa. This would make of the mucus a powerful protector against virus infections of the lungs.—J. F.

Experiences with 250 Cerebrovascular Accident Cases In a Chronic Disease Hospital

Symptomatology, Diagnosis, Course and Treatment

SIEGFRIED BAUMOEL, M.D., JOSEPH I. GOODMAN, M.D.,
and BERT A. TREISTER, M. D.

IN a recent study[1] of 1,219 chronically ill patients at the Cuyahoga County Nursing Home cerebrovascular accidents proved to be the frequent cause of major disability. One out of every five admissions (20 per cent) were thus affected. Not only is the cerebrovascular accident the foremost cause of prolonged morbidity but also it has become the third highest cause of mortality in the United States. Moreover, with the aging population the incidence of this condition will undoubtedly increase even more in the future. In view of the nihilistic attitude of some physicians toward cases of cerebrovascular accident the condition is frequently glossed over or neglected entirely.

The present series is composed mainly of long-term cases of cerebrovascular accidents which require different management than the acute cases. Most of the patients are kept at the Nursing Home indefinitely for sociologic reasons, thus affording an unusual opportunity to observe their course from day to day and evaluate the results of treatment. It will be shown herein that an energetic rehabilitation program restores the vast majority of patients to an ambulatory state and some have even been able to resume their former status in the community.

The present report deals with the incidence, symptomatology, course and management of 250 cerebrovascular accident cases many of which had been untreated prior to admission to the Nursing Home. It is beyond the scope of this paper to discuss the controversial aspects of the etiology, diagnosis and treatment of the condition. Suffice it to say, when every effort is made, not only to save the lives of this greatly neglected group of patients, but also to rehabilitate them, surprising results are frequently obtained.

NOMENCLATURE

The cerebrovascular accident is usually referred to as apoplexy, stroke, hemiplegia, cerebral hemorrhage, etc. Literally translated, "apoplexy" signifies a stroke. The very reference "apoplectic" connotes the doctor's indifference toward this illness. Many physicians, and even some textbooks, still use the terms "cerebral hemorrhage" and "cerebrovascular accident" interchangeably. However, since there are three main types of cerebrovascular accidents, namely, thrombosis, embolism and hemorrhage, their clinical differentiation is important from a therapeutic standpoint.

Submitted February 24, 1954

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In our cases of cerebrovascular accidents, and in the experience of others as well, thrombosis is encountered much more frequently than cerebral hemorrhage. In a series of 407 cases reported by Aring and Merritt[2] thrombosis was diagnosed in 81.8 per cent, hemorrhage in 15 per cent and embolism in 3.2 per cent. It can be seen that if every hemiplegia were loosely called "cerebral hemorrhage," the term would have been applied erroneously in most of the cases. While the term cerebrovascular accident ("CVA") is not ideal it will be used here for lack of a better one.

SYMPTOMATOLOGY

History of the attack.—In the differential diagnosis of thrombosis, embolism and hemorrhage an accurate history of the onset of the attack is extremely helpful. It is important to know whether the patient had been unconscious at the time of occurrence and following the "stroke." Usually the patient with a cerebral thrombosis does not lose consciousness and, without premonitory symptoms, develops a gradual hemiplegia at night or during the day.

By contrast, unconsciousness is the rule in the

patient with cerebral hemorrhage and he has an amnesia for the events just preceding unconsciousness and is unable to recall any details of the attack. As just stated cerebral thrombosis is the most common type of cerebrovascular accident and in our experience occurs three or four times more frequently than the other types. The underlying pathology of the thrombosis is atherosclerosis of the cerebral vessels and the end result of occlusion is infarction of the brain and encephalomalacia.

Cerebral embolism as a cause of cerebrovascular accidents is relatively uncommon as compared with thrombosis and hemorrhage, but when it occurs, it is usually secondary to cardiac disease and the patient is gravely ill. One obtains a history of a sudden onset of paralysis in a patient with a cardiac abnormality, for example, auricular fibrillation, valvulitis or murmur. A mural thrombus secondary to coronary thrombosis and myocardial infarction, or cardiac arrhythmias, may lead to cerebral embolism. Thus during auricular fibrillation, or an attack of paroxysmal tachycardia, a portion of a clot formed in the auricle may ultimately be lodged in a cerebral vessel by way of the blood stream. Occasionally, a thrombus in the region of the carotid sinus may be the source of emboli, and rarely so-called paradoxical emboli may emanate from thrombosis of peripheral veins getting to the brain through congenital atrial or interventricular defects.

Inasmuch as cerebral hemorrhage is one of the important sequelae of essential hypertension, a history of hypertension elicited in an unconscious patient with a CVA is consistent with a diagnosis of hemorrhage. Conversely, every CVA in hypertensive patients is not necessarily a result of a hemorrhage. Since both hemorrhage and embolism may have in common a sudden onset, unconsciousness and comparable degrees of paresis, the information necessary to differentiate these two conditions may be unobtainable.

Symptoms and signs: By means of the physical examination frequently one is able to ascertain the localization and extent of the lesion in cases of cerebrovascular accident. The motor cortex or the internal capsule are the two areas of predilection. A lesion in the motor cortex can produce either a monoplegia or a hemiplegia but it is the former which typifies a cortical lesion. On the other hand, the capsular lesion is always manifested by a hemiplegia, with or without disturbance of other functions (sensory, special senses, etc.). The so-called "thalamic hand," i. e., extension of all the phalangeal joints and flexion of the metacarpophalangeal joints, is encountered in some cases of capsular hemorrhage and is indicative of thalamic involvement. Conversely, recognition of a thalamic lesion will in turn establish more positively the localization of the CVA in the capsule, at the same time pointing to hemorrhage as the most likely etiology of the apoplexy.

A lesion of the left motor cortex in right-handed individuals usually produces an aphasia but in cerebrovascular accidents affecting the right side of the brain there is no interference with the central speech mechanism. The presence of aphasia localizes the lesion in either the cortex or subcortex. There are two predominant types of aphasia: (1) motor and (2) sensory. The patient with a motor aphasia, though cognizant of what he wishes to say, is unable to express himself and, upon finding his expressive vocabulary greatly curtailed, tends to be irritable and readily angered by the futile efforts to express himself. Sometimes, a patient with a mild aphasia may be able to recite certain habitual word sequences as, for example, the alphabet, his daily prayers, etc.

On the other hand, a patient with a sensory aphasia, though able to express himself normally, is unable to comprehend the spoken word and replies to questions and commands incorrectly. These patients attempt to conceal their defect by talking around the subject good-naturedly (paraphasia) and learn lipreading. While motor and sensory aphasia do occur in more or less pure form a combination of the two occurs much more frequently.

The lower portion of the face is paralyzed on the same side of the body as the extremities in many patients with cerebrovascular accidents. **Facial nerve** paralyses are constant findings in capsular lesions but occur only inconstantly, and in mild degrees, in cortical lesions. The occular branch of the facial nerve is occasionally involved slightly but, due to its bilateral innervation, is generally spared. When the orbicularis muscles are affected, it may be difficult to determine whether the facial paralysis is a result of an upper or a lower motor neuron lesion.

Homonymous hemianopsia is seen only in patients with lesions of the internal capsule. In conjugate paralysis the patient gazes toward the side of the brain in which the CVA is situated. Conjugate paralysis affects the internal rectus function on the same side and the external rectus of the side opposite the lesion.

The most common neurologic findings in patients with cerebrovascular accidents are the pathologic reflexes, namely, Babinski, Hoffmann, ankle clonus and the absent Léri and Mayer signs. While failure to elicit Mayer's sign is usually a good indication of an upper motor neuron lesion, absence of Léri's sign is in our opinion more reliable.

It is outside the scope of this paper to compare and evaluate the various neurologic signs observed in patients with cerebrovascular accidents, still in passing it is worthy to point out certain inconsistencies with respect to the Hoffmann sign. Frequently, it cannot be elicited in an abnormal

extremity, on the one hand, but may be observed in a perfectly normal extremity, on the other.

Usually the deep tendon reflexes are hyperactive and the abdominal reflexes greatly diminished or absent on the affected side. The latter finding may be unreliable because of a patient's flabby abdominal musculature, or some other reason. Rarely, a hand clonus may be demonstrable in the paralyzed arm. When a lesion of the internal capsule extends to the nuclei of the basal ganglia the deep tendon reflexes of the affected side, instead of being hyperactive, may actually be normal or even diminished. The paralyzed extremities are usually colder to the touch than the normal side and edema, probably due to vasodilation, is a very common finding. While emotional symptoms are much more common in patients with pseudobulbar paralysis, still, varying degrees of instability may also occur in unilateral CVA's.

After a cerebrovascular accident some patients complain of a disagreeable, warm, burning, deep, constant, nonradiating pain on the affected side of the body. The hyperesthesia may be so severe that mere weight of the bed clothing, or even a draft, is a sufficient stimulus to evoke the disagreeable sensation although direct pressure on the skin has no effect. This sensory disturbance, the so-called hyperpathia of Foerster, is especially characteristic of thalamic lesions, though occasionally encountered in lesions of the medulla oblongata. Thalamic pain is very intense and usually does not respond to analgesics.

DIAGNOSIS OF CEREBROVASCULAR ACCIDENTS

Basically, a patient who has had a cerebrovascular accident presents the Wernicke-Mann type of hemiplegia, i. e., flexion of all the joints of the upper extremity and extension of those of the leg. The distal portion of the upper extremity is more seriously impaired than the proximal. The affected leg appears longer than the opposite leg compelling patients to walk with a circumduction gait. A lesion other than a CVA should be suspected in patients who do not present the Wernicke-Mann hemiplegia.

Whereas the internal capsule is statistically the most frequent site of involvement in cases of hemiplegia, when a monoplegia occurs, especially with associated aphasia, the motor cortex is the site of damage. The patients with capsular lesions usually show more extensive and serious involvement as compared with those with cortical lesions.

The possibility of a syphilitic cerebrovascular accident can usually be ruled out by examination of the cerebrospinal fluid. The widespread opinion that a diagnosis of vascular neurosyphilis is compatible with an entirely negative spinal fluid is probably invalid. In cases of so-called syphilitic endarteritis with a negative spinal fluid the neuropathologist Pentschew and Jahnel, a clinician, proved that the lesions of the small cortical blood vessels are nonsyphilitic. On the other hand, certainly there are syphilitic patients in whom irreversible nerve tissue changes have occurred prior to the institution of specific therapy. In cases of CVA the differentiation of luetic from arteriosclerotic tissue change, in patients in whom active syphilis has been eradicated by treatment, is very difficult.

Cerebral trauma, which results from the area of brain that has been damaged, may produce almost any clinical picture. Occasionally fat embolism is the etiologic factor in cases of CVA. The emboli originate at a fracture site, a rib, for example; they are usually multiple and produce lesions in the brain. Complete recovery is the rule. In a patient with hemiplegia the possibility of an underlying brain tumor must never be overlooked.

COURSE AND TREATMENT

Course: Whereas the affected extremities are usually flaccid at the onset of a CVA, spasticity develops ultimately. Patients confined to bed are inclined to maintain the extremities in flexion and, unless appropriate measures are instituted, contractures develop not only on the affected side but frequently on the normal side as well. The vascular changes associated with hypertonia or hypotonia may cause considerable pain. Periarthritis, to which inactive patients are particularly prone, may lead to painful contractures. Actually, the tissue changes may be so extensive in joints with contractures that a corrective procedure (turnscrew cast, capsulotomy, etc.) must be performed as a prelude to walking training. Aside from contractures, or some other untoward complication, one can expect complete functional recovery in the vast majority of patients with CVA's.

Treatment: A pessimistic attitude toward the management of cases of CVA's is not warranted in the light of our results. Every effort should be made to rehabilitate these patients. The treatment immediately following the onset of hemiplegia entails supportive measures, physical therapy, general rehabilitation and walking training. Unconsciousness and sphincter incontinence, which may be present in the acute phase, usually clear up in a few days. Adequate nutrition must be ensured from the start and those patients who are unable to swallow should be given nourishment by a polyethylene tube inserted through the nose into the stomach. Decubitus ulcers can be avoided by turning the patient frequently and antibiotics should be utilized prophylactically to ward off pneumonia.

During the acute phase of a CVA, in which flaccidity of the paralyzed arm and leg persists for a period of two to four weeks, attention should be directed toward the prevention of contractures.

In order to prevent contracture deformities during this flaccid stage a splint can be applied to hold the wrist and hand in the neutral position and the patient should be encouraged to keep the involved knee fully extended. External rotation of the hip is prevented by sandbags placed on both sides of the leg. Footdrop also can be prevented by use of sandbags or a footboard to hold the foot at a right angle.

Passive movements of the paralyzed extremities through a full range of motion should be performed two or more times daily from the onset. Particular attention should be given the joints of the upper extremity (hands, wrist and shoulder) which are extremely susceptible to contractures. For example, the entire arm should be moved through the full range of abduction and external rotation to prevent the so-called "frozen shoulder." Ordinarily these procedures are done by a nurse or attendant and some patients can perform these movements for themselves with the aid of their normal hand or a system of pulleys. Good nursing care cannot be overemphasized during the early states when the patient is still bedridden.

The patient should be encouraged to use the affected upper extremity for eating and other daily needs as early as possible. As soon as his general condition permits, the patient should sit up in a chair. A straight back arm chair of a convenient height for sitting comfortably with both feet on the floor is satisfactory. The patient's sitting time should be increased progressively starting with approximately one hour daily. Wheelchairs are unsuitable to use for sitting.

In view of the importance of early ambulation this should be the objective in every patient with a cerebrovascular accident. When a patient is able to sit in a chair several hours daily he is ready for weight bearing. He can be assisted to a standing position bearing weight on the normal leg. The patient learns to assist himself with his normal hand by pushing against the arm of the chair at the same time holding the back of the chair for support. After repeating this maneuver several times daily the patient is soon able to stand unassisted. Walking training can be instituted at this point under the guidance of a physical therapist, nurse or an attendant and using a cane for support. Frequently, a four-legged lightweight walker without wheels or stationary parallel walking rails can be used effectively.

In case walking is hampered by marked footdrop, a calf-length double bar brace with a right-angle stop may be applied to the ankle. Inversion or eversion of the foot can be corrected by a T-strap attached to the shoe.

As a rule, in hemiplegic patients the upper extremity recovers more slowly and less completely than the lower extremity. If there has been little or no recovery of active motion in the upper extremity after three months, further improvement is not likely. Occupational therapy should be instituted promptly with the first indication of hand motion and is designed to develop the involved hand to assist the normal extremity in carrying out the patient's daily needs.

Some patients experience thalamic pain in the affected arm and leg, others complain solely of severe pain in the shoulder as a result of a contracture of the muscles and ligaments. The pain is alleviated principally through increasing the range of shoulder motion by diathermy, local massage and active and passive exercise even to the point of discomfort.

Motor aphasia is a serious handicap frequently associated with right-sided hemiplegia in patients with cerebrovascular accidents. If a patient's speech has not returned spontaneously by three months there is little chance of further recovery. However, in those in whom substantial recovery occurs, speech therapy can be beneficial.

When hand function fails to recover in a right-handed individual he may be instructed to write with the left hand.

RESULTS

Results of treatment in our cases: In appraising the results of treatment in this group of hemiplegic cases it must be recognized that few had the advantage of physical therapy and rehabilitation treatment prior to admission. Further, in order to set a goal for treatment the ability to evaluate the various neurologic lesions is important. In other words, some abnormalities are reversible, others irreversible. Hence, brain function may be so seriously impaired as to make any further rehabilitation impossible in which case the goal may be merely walking. Some patients are not treated with physical therapy but, because of advanced neurologic changes particularly sensory aphasia, must remain wheelchair patients. Others are not treated actively but are forced to remain in a wheelchair because of the presence of flexion contractures of the knee where surgeons have deemed it inadvisable to use corrective measures preliminary to walking training.

As a result of numerous observations we can say that, irrespective of the degree of active movement in the hemiplegic extremity, the great majority of patients can be taught to walk although some may require the assistance of a walker or cane. Approximately 75 per cent of the patients admitted in various stages ultimately were able to walk with or without the use of some apparatus or walker. It should be realized that many cases had no early treatment and a much larger proportion of the patients would be walking were treatment instituted promptly. Patients in whom the upper extremities are totally paralyzed, and complicated by marked

spasticity and flexion contractures, fail to improve with any kind of treatment. Nevertheless, with occupational therapy, they learn to use the affected extremity to assist the uninvolved one. Patients in whom there was no function in the upper extremities on admission failed to improve at all.

Many patients learned to take care of themselves as to dressing, eating and bathing. When, together with walking, a substantial amount of upper extremity function is present, the patients qualify for discharge to a custodial arrangement.

SUMMARY

Because the cerebrovascular accident is the leading cause of all major disabilities in this country we are presenting our experiences with the diagnosis and management of 250 cases at the Cuyahoga County Nursing Home. Of the three leading causes of cerebrovascular accidents, namely, thrombosis, embolism and hemorrhage, thrombosis is encountered in the vast majority of cases. The history of onset of the attack proves to be the most valuable aid in differentiating these three conditions. The finding of hypertension and blood in the spinal fluid are more indicative of a cerebral hemorrhage, a cardiac disorder suggests embolism and the presence of atherosclerosis predisposes to thrombi.

A brief discussion of the rehabilitation methods employed in these cases is given. When every effort is employed to rehabilitate these patients, even previously untreated cases, the vast majority are able to ambulate and many regain function of the upper extremity as well. Our results prove the efficacy of active treatment in cerebrovascular accident cases and furthermore point up the necessity for treatment in the early stages.

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Dangers Involved in Obtaining Bronchogram

The dangers involved in doing a bronchogram are relatively few. It would be unwise to do the procedure in the presence of an acute infection. In patients with limited lung capacity one should use as little lipiodol® as possible and maintain constant observation throughout the procedure.

By far the most frequent difficulty encountered is sensitivity to local anesthesia, but premedication and the use of the anesthesia in small amounts will help to overcome this mishap.—Arthur J. Cracovaner, M. D., New York City: *New York State J. M.*, 54:1931, July 1, 1954.

Medical Needs and Absenteeism In a Healthy Population

Two important questions in the area of general health are: (1) What is the extent of the medical requirements of a group of individuals highly screened on health requirements over a given period of time? (2) To what extent do these requirements result in absenteeism, i.e., interefere with job performance? . . .

These questions are difficult, if not impossible to answer, from the activities of the typical medical facility. For example, the extent of the use of medical facilities is markedly affected by their availability in terms of their number, their geographical location and the economic consideration inherent in their use. Further, if more than one medical facility is available in the general area, it is difficult to know the nature and the extent of the population being treated by the individual facility. In most instances, we do not know the level of the health of the population being treated. In regard to the effects of the medical complaints on the work performance of the individuals being treated, records are seldom kept. Although such records are frequently maintained in an industrial medicine facility other required data are often unavailable.

Recently, data on 1,080 Naval Aviation Cadets extending over an eight-month period have become available. These data give the number of times each individual visited a medical dispensary which was available to care for their needs and also the resulting administrative action that was taken by the dispensary in regard to his continuing his routine activities. Such a population has the characteristics of complete and unrestricted availability of its facilities with a defined health level for the group. The purpose of this paper is to report the findings. . . .

The dispensary visits of the 1,080 cadets for eight months were studied. It was found that the extent of dispensary visits was considerable: about six men in 10 made at least one dispensary visit during the period; the number of sick calls ranged from 0 to 43; 5 per cent of the group made 10 or more visits, and 10 per cent of the group made five or more visits during the period of time studied. Fortunately, the medical requirements did not result in extensive interference with job performance: 67 per cent of the visits resulted in immediate return to duty; only 33 visits required hospitalization; only one-tenth of one per cent of the man days available during the period were lost to off-duty assignments.—Wilse B. Webb, Ph. D., Pensacola, Fla.: *Industrial Med. & Surg.*, 23:416, September, 1954.

Tuberculosis

A Pediatric Review

FRANK W. KELLOGG, M. D.

TO attempt a comprehensive review of all current tuberculosis literature and still remain within the scope and purpose of such a paper would be impossible. To publish therapeutic results of one or more series of miliary tuberculosis or tuberculous meningitis cases would be likewise beyond the intentions of such an article. Rather it is intended to review some of the more recent articles on the subject of tuberculosis in general, with emphasis on the changing concept of therapy and management and the prognosis of tuberculous meningitis in particular.

Such a review may be especially timely, since despite national figures that indicate a decreasing morbidity and mortality, tuberculosis admissions (new cases requiring hospitalization) to the Pediatric Services of the Cincinnati General and Cincinnati Children's Hospitals and the children's ward of Dunham Hospital of Hamilton County for the first six months of 1954 already number 37. It has been stated that a decrease in morbidity in tuberculosis has not kept pace with the decreasing mortality.[1] Such a situation only serves to emphasize the imperfections in our case finding methods, prevention programs and abilities to diagnose and institute early antituberculosis therapy.

SOME DIAGNOSTIC AIDS

Several authors of current articles have gone to some lengths to reiterate diagnostic criteria for tuberculous meningitis, feeling that often precious time is lost trying to distinguish this dread complication from other entities that call forth similar changes in the cerebral spinal fluid. Lincoln and Sifontes[2] stress particularly the necessity of smearing and staining the spun-down sediment and pellicle for acid-fast bacilli, such fluid to have been centrifuged at 2000 to 3000 revolutions per minute for at least a half hour and searching of the smear to take not less than two hours![3]

The spinal fluid chloride level is too often of no help, since it frequently does not fall until later in the course of tuberculous meningitis. Interestingly enough, the fluid control biochemists maintain that they can demonstrate serum electrolyte changes, which may aid in corroborating such a diagnosis, since these patients frequently have a high CO_2 content, a *p*H of over 7.5, and decreased serum sodium, potassium, phosphate and chloride levels. However, despite a low chloride level in the serum, the total body chloride content or total chloride space is normal or even slightly increased. It is almost impossible to change this low serum chloride value by administering parenteral chloride solutions.

Taylor, Smith and Hunter[4] have demonstrated an alteration in blood-spinal fluid barrier physiology to the bromide ion in tuberculous meningitis and suggest that such a phenomenon can be adapted to a diagnostic test. Normally there is two to three times as much bromide in the serum as in the cerebrospinal fluid after the oral or intravenous administration of known amounts of sodium bromide. However, in active tuberculous meningitis, because of increased permeability, this gradient tends to be equalized and bromide levels approach the same concentration in the two body fluids. These observations have been made in other purulent meningitides, but only very rarely.

Such an increase in the meningeal permeability is demonstrable also by the finding of increased concentrations of streptomycin in the spinal fluid of patients, who have local inflammatory changes in the meninges, following the intramuscular injection of the drug.[2]

By far the majority of contemporary articles have dealt not with diagnosis of the various forms of tuberculosis, but rather with their therapy.[5,7,8,9,10,11,12] Between 1930 and 1947 Lincoln reported a 21.5 per cent case fatality rate for all forms of tuberculosis in children in a twenty year follow-up study. This percentage has since fallen to 1.5 per cent. Before the advent of specific antituberculous drugs the death rate for tuberculous meningitis was 100 per cent. Streptomycin and promizole reduced this figure to 37 per cent and now, with the aid of isonicotinic acid hydrazide, the mortality rate has been pared to 12 per cent!

Dosage and schedules are nearly as numerous as are case series reports. Rather than discuss each suggested regimen separately, it might be of more benefit to review some of the principles

Submitted July 15, 1954.

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of therapy that are generally agreed upon by the various workers in this field.

SPECIFIC ANTITUBERCULOUS DRUGS

Streptomycin is both bacteriocidal and bacteriostatic in its mode of action and is generally given in 50 to 100 mgm. per kg. doses intramuscularly. Five to ten gamma/cc. blood levels are usually effective, although it may take levels of 25-50 gamma/cc. to kill the tubercle bacillus inside a monocyte. Most physicians are initiating streptomycin therapy on an every day basis for four to six weeks and then switching to a twice weekly schedule. There is no difference in therapeutic efficacy between streptomycin and dihydrostreptomycin. Streptomycin is more apt to cause vestibular toxicity relatively early in comparison with dihydrostreptomycin, which gives rise to deafness later in the course of therapy. There are fewer allergic reactions to the latter drug, but apparently no differences between the two in frequency of emergence of drug resistance. Streptomycin does not hasten the resolution of a primary complex. Aerosol streptomycin has been found to be of definite help in treating endobronchial disease in children.

Para-aminosalicylic acid is a bacteriostatic drug usually given in 0.2-0.4 Gm./kg. doses to prevent the development of streptomycin-resistance. It may cause gastric irritation, but children tolerate it fairly well in an elixir made up with soda bicarbonate (12 per cent) and syrup of cinnamon.

Promizole is another bacteriostatic agent that is tolerated well by children and is ordered in increasing amounts until a 1-3 Gm./day dose is reached or until a 1-3 mgm. per 100 cc. blood level is obtained.

Isonicotinic acid hydrazide (INH), a bacteriostatic antimicrobial, is given in doses of 4-10 mgm./kg. Larger doses have been shown to be no more effective and may give rise to troublesome toxic manifestations. Many INH treated patients are said to have transient abnormal liver profiles. The INH molecule appears to be relatively small and is able to penetrate the central nervous system readily and also enter the individual cell. Its mode of action is thought to be that of an essential metabolite competitor. Since its introduction in 1952, the tuberculosis survival rate has gone up; the number of relapses decreased; the emergence of streptomycin-resistant strains of the tubercle bacillus lessened; the length of treatment diminished, and most miraculous of all, it is thought that INH may prevent the development of complicating tuberculous meningitis.

Before INH was available meningitis developed in 70 per cent of all cases of miliary tuberculosis. Observations to date have failed to show the development of tuberculous meningitis in a single patient while on INH therapy. So intriguing is this possibility that Dr. Edith Lincoln has set up a controlled study, treating alternate primary cases (including tuberculin test converters) with INH to see if such preliminary observations are correct. INH will be given for a year on the grounds that development of meningitis after this time is exceedingly unlikely. INH has not proven as efficacious in tuberculous adenitis and osseous tuberculosis. Streptomycin and INH may have a synergistic effect.

The treatment of tuberculous meningitis with cortisone, in conjunction with the usual antibiotic and chemotherapeutic agents, has been reported by Shane and Riley[6] in rather glowing terms. If used in time, comatose and almost moribund patients have recovered, and particularly spinal blocks either have been prevented from forming or actually dissolved. These authors maintain that cortisone may be used safely, provided the patient is adequately covered with antituberculous drugs.

Similar recommendations have been made by the orthopedists, who say that with the aid of adequate antimicrobial therapy, they are now able to undertake radical surgery much earlier, thus cutting by months the length of hospitalization.[13] Antituberculous drugs alone, however, have been disappointing in the treatment of bone and joint tuberculosis.

Viomycin® is effective, but fairly toxic and results are no better. Hence, the use of this drug is limited to those cases that have become resistant to the other agents.

Pyrazinamide (aldinamide®) in preliminary reports has been shown to be a most effective antituberculous medication, but further investigation of its toxic reactions is necessary before its true value will be known.

DURATION OF THERAPY

A crude rule of thumb for therapy might well be—to treat all cases of pulmonary tuberculosis for a minimum of six months; all miliary cases for at least one year and tuberculous meningitics not less than 18 months. Another good rule to follow in the management of the tuberculous patient is to do weekly spinal taps on all cases of miliary tuberculosis or any case of active tuberculosis, if the patient shows persistent fever or lethargy. In the treatment of any form of tuberculosis it is advisable to use combinations of any two or three antituberculous drugs, but always keep one in reserve should the need arise. This dictum would apply to other forms of tuberculosis also.

Should a spinal block develop during the course of treatment of a case of tuberculous meningitis, several procedures are available, such as:

(1) injection of air intraspinally at the lumbar level;

(2) intracisternal or intraventricular injection of streptomycin;

(3) intraspinal streptokinase or streptodornase or purified protein derivative;

(4) craniotomy with neurosurgical lysis of basilar adhesions or

(5) administration of cortisone.

None of these several alternatives is completely effective and may well be quite disappointing—hence the admonition again of early diagnosis and institution of proper therapy.

Before leaving the discussion of therapy, something should be said regarding the status of surgery in pulmonary tuberculosis of the pediatric patient. Segmental or lobar resections for bronchiectatic or cavitary disease have the same indications and are as effective in children as in adults.

Supportive care of the tuberculous child is still of great importance and should not be overlooked in this age of specific antimicrobials.

SOME FACTORS AFFECTING PROGNOSIS

Some factors other than antituberculous agents affecting prognosis may be worth considering also. Of prime importance in discussing the prognosis of tuberculous meningitis is the stage at which therapy is instituted. Results are more apt to be poor, if the patient has already developed changes in sensorium before therapy is begun. Dr. Lincoln has placed the average duration of the untreated disease at 19½ days, i. e., from onset of symptoms until death.

If permanent neurological residua are to be prevented, adequate treatment must have been started long before the development of cerebral thrombosis and endarteritis. Consequently, it has been suggested that antituberculous therapy be immediately instituted for any meningitis that shows: (1) a predominantly mononuclear pleocytosis; (2) a decreased cerebrospinal fluid sugar; (3) failure to grow any pyogenic organisms in 24 to 48 hours and (4) a positive tuberculin test or evidence of tuberculosis elsewhere in the body.[7] If therapy is to be successful, the patient will usually become afebrile within one to three months; begin to gain weight in two to three months and show improvement in cerebrospinal fluid findings within two to four months.

The question of intrathecal medication is undecided at this time. To be sure, INH has helped greatly in reducing the amount and length of such treatment. Whether or not intrathecal therapy can be abandoned entirely will depend on the results of more controlled studies.

There is also disagreement as to whether or not the case of tuberculous meningitis is complicated by and the prognosis altered with the coexistence of miliary disease elsewhere in the body.

It may be worth emphasizing again that neurological sequelae and even varying degrees of mental retardation may continue to improve over several years after antimicrobial therapy has been stopped. Relapses must be looked for and therapy reinstituted immediately in such an event. Most recrudescences usually occur within six weeks after stopping therapy, although a few have been reported much later than this.

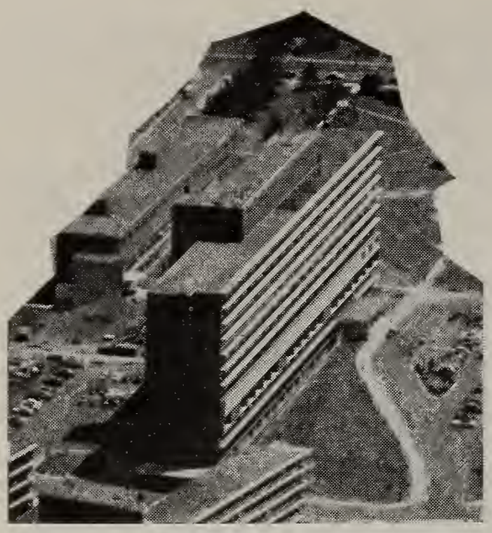
BCG VACCINATION

No discussion of present day tuberculosis would be complete without a word concerning BCG vaccination. Wallgren has written an excellent review covering materials, methods and results.[14] The efficacy of such a procedure is still being bantered back and forth, although sufficient data are now available to attest the value of a BCG vaccination program. Comparatively speaking, BCG is not as effective in protecting and preventing tuberculosis as the vaccination for smallpox is in preventing that disease. BCG probably is not too effective on a mass scale, but for babies born into families with strong positive tuberculosis histories, it has definite value. Certainly nurses, doctors and sanatorium personnel groups have benefitted. BCG has been thought to cut down on the number of progressive primary cases, the development of tuberculous pleuritis and the late destructive lesions in the event that the vaccinated person should develop the disease. Wallgren had thought that complicating tuberculosis meningitis was being prevented in the BCG vaccinated group. However, two of the five children developing tuberculosis in our BCG series (now over 1100 children) subsequently developed meningitis.

Since prevention is a surer route than treatment in the eradication of a disease, it behooves us to continue any and all efforts to protect against that disease and certainly BCG vaccination should be continued in selected situations.

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A Case Record

From The University Hospital,
Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Burr M. Hathaway, M. D., President

Presented by B. K. Wiseman, M. D., and Emmerich von Haam, M. D. Edited by E. von Haam

PRESENTATION OF CASE

TWO years before his demise this 33 year old white male developed a non-productive cough with progressive dyspnea, weakness and fatigability. Numerous diagnostic studies were done. A diagnosis of pulmonary fungus disease was made at a Veterans hospital and the patient started on potassium iodide, with no relief of symptoms. Fifteen months before his death he was admitted to another Veterans hospital, where a lung biopsy specimen was taken which showed "abnormal calcification of the lung."

The patient was treated with intermittent positive pressure oxygen and aerosol epinephrine, which brought about marked subjective and objective improvement. Within the next six months, however, his dyspnea and weakness again became marked and he developed a persistent elevation in his evening temperature.

ON ADMISSION

He was first admitted to University Hospital eight months before his death complaining of shortness of breath and fatigue. At the time of this hospital admission the microscopic slides of the lung biopsy were reviewed and were interpreted as pulmonary fibrosis. The patient was started on cortisone. Four months after his first admission he was readmitted following another episode of progressive dyspnea, weakness, cyanosis and fever. A chest x-ray at this time showed cardiac hypertrophy and dilatation and chronic passive congestion of his lungs superimposed on pulmonary fibrosis. The patient was treated with penicillin, crystodigin® and oxygen, and cortisone was continued. He was released after 3 weeks; however, he remained in bed at home with oxygen at his bedside.

After a few weeks at home he developed an upper respiratory infection with chest pain and severe dyspnea for which he received 100 mg. of demerol® every 4 hours. He had intermittent fever with daily spikes to 103°F. The temperature became normal on the ninth hospital day. It was felt that the patient was developing cor pulmonale. He was released after 5 weeks of hospitalization. He remained at home for 3 weeks but became more dyspneic, developed chest pain and complained of a sore mouth which interfered with eating. He was therefore again admitted to University Hospital (2 months before his demise). He had been taking digitoxin 0.1 mg. daily, demerol® in progressively increasing amount (about 1500 mg. daily) and an additional butisol® tablet four times a day.

The past history revealed that he had had pneumonia as a child and again while in military service in the Philippine Islands in 1945. At that time the pneumonia followed a concussion injury from a grenade. He also had malaria, dengue fever, epidemic diarrhea and scrub typhus while serving in the Pacific theater. No other toxic or injurious exposures were known.

Physical Examination: At the time of his final hospital admission the patient was a well-developed and well-nourished white male lying quietly in an oxygen tent and exhibiting labored breathing and moderate anxiety. His temperature was 97.8°F., pulse 92, respirations 28, blood pressure 130/70. The skin was moist and cool. The mouth showed many red areas of inflammation covered with patches of grayish exudate. The chest had equal expansion; there was moderate diphragmatic breathing. The breath sounds were fairly clear with frequent fine rales throughout both lung fields. Examination of the heart showed tachycardia but no murmurs. The abdomen was moderately tense. There were 1 plus pedal edema, clubbing of the fingers and cyanosis of the nail beds.

Laboratory Data: The red blood cell count on admission was 5.13 mil. with a hemoglobin content of 13.25 Gm.; the white blood cells numbered 13,000 with a differential count of 70 per cent neutrophils, 20 per cent lymphocytes, 2 per cent

eosinophils and 2 per cent monocytes; the corrected Wintrobe sedimentation rate was 36; the hematocrit was 43.5 per cent. Urine examination gave normal findings. Serum electrolytes and CO_2 combining power were normal. Blood serology was negative for syphilis. Alpha Streptococci, Neisseria and yeasts were cultured from the lesions in the mouth. Previous sputum studies had been negative for acid-fast organisms. The tuberculin test was strongly positive in 48 hours. Histoplasmosis skin test was slightly positive in 48 hours.

An electrocardiogram taken 3 months before his death was interpreted as showing sinus tachycardia with secondary T-wave changes.

X-Ray Data: Chest x-rays showed diffuse pulmonary fibrosis with such severe fibrotic changes that it was impossible to distinguish the margins of the cardiac silhouette. The fibrosis observed in 1952 was of the same degree as that at his last admission. It was evenly noticeable over both lungs in a lymphatic type of distribution. The last film showed small areas of emphysema. The picture was interpreted as some type of chronic lymphatic sclerosis with sarcoid as the best possibility. On the other hand the picture was also considered compatible with a diagnosis of beryllosis or silicosis if the antecedent history showed some exposure to them. It was not considered typical of a fungus infection of the lungs.

Hospital Course: The lesions in the mouth and pharynx were attributed to Monilia infection as is commonly observed in cases receiving extensive antibiotic therapy. Treatment with 1 per cent gentian violet caused marked improvement. The patient was placed on a low sodium diet and the edema subsided. The narcotic addition (demerol® 1500 mg. daily) proved a difficult problem. However, after ACTH therapy there was a marked decrease in demand for demerol® and a marked increase in the patient's well-being. The demand for oxygen lessened and when the patient was discharged after 18 days of hospitalization he was able to be without oxygen periodically during the day.

One month after his discharge the patient's wife called the family physician to report that the patient had suddenly died. He had sat up in bed stating that he did not feel well and when she arrived at his bedside he was dead.

CLINICAL DISCUSSION

DR. B. K. WISEMAN: I would like to point out some of the main features of this case. This man apparently had been ill for only approximately 2 years before he died. He was perfectly all right and then in the matter of just a few days he found that he was unable to climb stairs without a great deal of dyspnea, which would indicate a rather rapid onset. His chief complaints all through his illness were weakness, coughing and dyspnea. He had had no hemoptysis. Interestingly enough, on his first hospital admission outside of town, at a Veterans hospital, a biopsy was done and yielded rather negative information in that the only thing found microscopically was fibrosis.

The past history does not help very much except to rule out certain possibilities. He did have pneumonia as a child and again in 1945. He had no contact with any injurious agents and there was no exposure to beryllium or silicosis.

The only abnormal findings of his physical examination were related to the chest. He was continually cyanotic. The chest showed equal expansion, mostly diaphragmatic breathing. The breath sounds were fairly clear. There were a few moist rales throughout both lung fields but no dullness or consolidation. Apparently his chest was not unduly hyperresonant and really showed very little physical signs as that description would indicate. The heart was normal throughout.

LABORATORY FINDINGS

So far as the laboratory work is concerned, little more can be said than that it was noncontributory. As you might surmise, everything was done to this man, to his sputum, blood, etc., but at no time was anything discovered that appeared to be of any significance. His condition persisted that way through all hospital admissions. He was treated in a rather nonspecific fashion, chiefly with oxygen intermittently. He was sent home after his fourth hospital admission and then died at home, apparently a sudden death.

Obviously the whole problem revolves around a chest disease of some kind characterized by pulmonary fibrosis. When surveying the possible causes for pulmonary fibrosis it is a useful plan to consider the various anatomic structures of the lung that can be involved in fibrotic lesions, and I think that Spain,[1] who has done a great deal of work on this, has a good system to follow. He divided the fibrosis of the lungs into four chief types: the bronchiolar fibrosis, the parenchymal fibrosis, the perivascular fibrosis, and the interstitial type of fibrosis. All the various diseases which cause fibrosis fall more or less into one of these four types. There may be some overlapping, of course, but usually one or another of these four patterns can be recognized.

In the bronchiolar type there is a deposition of fibrous tissue around the bronchioles with a narrowing of the bronchioles followed by an obstructive type of emphysema which produces pulmonary hypertension and a cor pulmonale. A very common type of this fibrosis is exemplified by chronic bronchitis with bronchiolectasis, which nearly always leads to emphysema. I certainly don't think that a bronchitis or bronchiectasis would result in a type of fibrosis in which the individual would be dead inside of two years because of inability to get air into his lungs.

In bronchial asthma you have complete contractions of the bronchioles and there occurs often a

certain amount of secondary infection which leads to chronic bronchitis with fibrosis, emphysema, cor pulmonale, etc. It would seem that asthma is not in the background here. There is too much fibrous tissue and the patient really had no asthma history.

In the parenchymal types of fibrosis one observes mainly involvement of the bronchioles and alveoli, which are destroyed in rather patchy fashion. Diseases that produce this particular type of fibrosis are the mycotic infections such as histoplasmosis, coccidioidal mycosis, moniliasis, torulosis, blastomycosis and tuberculosis. I think we can dismiss tuberculosis in this patient because all attempts to recover tubercle bacilli both by culture and biopsy were unsuccessful on all occasions. Equally it seems to me that if this man had a mycotic disease they should have been able to recover the fungus. They did culture some Monilia from his throat, but that was only after he had been on heavy antibiotic therapy which as you know encourages the growth of Monilia in the nose, throat and nasopharynx. The lung biopsy did not show any yeast-like organisms. So I doubt that he had had pulmonary mycosis.

"DUST DISEASES"

The dust diseases which mostly involve the parenchyma of the lungs are pretty well ruled out too. This includes silicosis, siderosis, asbestosis and berylliosis. I think that until somebody can prove exposure to a harmful dust it would be rather foolish to consider any of the pneumoconioses too strongly as a probable diagnosis. Some claim that you may have exposure and not know of it. They tell some remarkable tales about people who drive past factories where they use beryllium and contract berylliosis.

We can also exclude radiation fibrosis since he did not get radiation treatment. Because of the bilateral distribution we also can exclude fibroid or organizing pneumonia. Since his fibrosis was much more pronounced than his emphysema, I am also excluding primary or idiopathic emphysema.

As we come to perivascular fibrosis we are reminded immediately of the collagen diseases, such as periarteritis nodosa, lupus erythematosus or dermatomyositis. Of course they are not too common diseases, but this man obviously did not have a common disease. We also must not forget that a collagen disease of whatever variety is a systemic disorder. The patients run a good deal of fever, lose weight and get anemic. This man did not do that. So I consider that as supportive evidence that he probably did not have a collagen disease.

What about blood dyscrasia? I think it would be possible for Hodgkin's disease to show a chest like this; I am sure it would, as a matter of fact, and I have seen them worse than this with Hodgkin's infiltration. But again, Hodgkin's disease is a systemic disease. People go downhill, they show all the signs of going downhill the same as they do in the collagen type of diseases, and this man did not have that type of clinical picture. Monocytic leukemia will also give a lung picture like this, but neither his blood counts nor the course of his disease support that diagnosis.

So far as Boeck's sarcoid is concerned, I would agree that involvement of the lungs by sarcoid is common. Against sarcoid, however, speaks the fact that the majority of people get well and do not die of sarcoid. They also obtained a lung biopsy on this man and they did not find the typical lesions of sarcoidosis. Furthermore this man did not show any lymph nodes to speak of. When I first looked at the x-ray plates it looked to me more like a diffuse pulmonary carcinomatosis than anything, but where the cancer would originate I don't have the least idea in the world. It certainly would have to be metastatic. Although improbable, this remains definitely in the realm of possibility.

DIFFUSE INTERSTITIAL PULMONARY FIBROSIS

Finally, I come to my favored diagnosis of this case: a disease described by Louis Hamman and Arnold Rich[2] back in 1944 and called "diffuse interstitial pulmonary fibrosis." It was described as an acute type of disease and all their patients died within 2 months. They studied four individuals and at autopsy they found nothing but fibrous tissue throughout the lungs somewhat in the same fashion as shown in these x-ray plates. There have been a number of cases described since. The last series that I read about was in 1952,[3] in which 16 cases had been reported, but the experience had varied a little bit from Dr. Hamman's original report and some of these individuals lived as long as 7 years. It was not infrequent for them to live 2 to 3 years. In other words, they proved not quite as acute as Dr. Hamman originally thought, if one can accept the 16 cases which have accumulated in the literature.

The sudden onset and the chest symptom of cough, dyspnea and cyanosis are extremely important for the diagnosis. Some patients have a little fever, others none. Some of them have some weight loss. An occasional patient suffers from hemoptysis, but by and large the patients die from primary pulmonary insufficiency with eventual development of cor pulmonale and right heart failure. So that so far as I can see in terms of the facts that I have learned, the clinical course would best fit the disease of Hamman and Rich, which they named acute diffuse interstitial pulmonary fibrosis. In this particular instance I suppose one would label it subacute, or perhaps even chronic, pulmonary fibrosis.

As far as the death of the patient is concerned, I think that it is very likely that he died of

respiratory failure due perhaps to too liberal use of oxygen. As you know, these individuals with cor pulmonale have a high CO_2. When you put them on 100 per cent oxygen for a long period and get rid of the CO_2, they just can't breathe properly and they die. That is a very common method of death and it might have been the cause here. Of course there are other things that might have killed this man: emboli, heart disease of the more dramatic type, or an acute respiratory infection. Individuals who have pulmonary emphysema with a cor pulmonale cannot tolerate even a little minor cold. They get a few sniffles and they look like they are dying and they really are. Maybe this man caught an upper respiratory infection that was just too much for him and he died very rapidly.

So my final conclusion is that this patient suffered from a condition of diffuse interstitial pulmonary fibrosis described by Hamman and Rich. My second choice for the clinical diagnosis would be that of Boeck's sarcoid. I see no strong arguments against the diagnosis of sarcoid except the interpretation of the pulmonary biopsy and the fact that he did not develop enlarged lymph nodes.

CLINICAL DIAGNOSIS

1. Diffuse pulmonary fibrosis.
2. Cor pulmonale.

GENERAL CLINICAL DISCUSSION

DR. E. VON HAAM: That was a very good presentation and a very definite diagnosis of his illness. Any questions?

DR. R. A. MAYERS: Where does pulmonary arteriosclerosis fit into your classification?

DR. WISEMAN: That occurs chiefly in cases of pulmonary emphysema with pulmonary hypertension.

DR. MAYERS: Isn't there a primary disease of pulmonary sclerosis?

DR. WISEMAN: You mean Ayerza's disease, or primary pulmonary arteriosclerosis?

DR. E. K. RYDER: That would fall into your group of vascular diseases, is that right?

DR. WISEMAN: Those cases don't usually show very much fibrosis. There is primary involvement of the vessels by arteriosclerosis. The Ayerza's type of sclerosis produces severe cyanosis and an increased pressure in the lesser circuit but not much fibrosis. Emphysema is the common lesion in the lungs here.

PATHOLOGIC DIAGNOSIS

1. Chronic bronchiectasis with cyst formation.
2. Diffuse pulmonary fibrosis.
3. Compensatory pulmonary emphysema.
4. Cor pulmonale.
5. Complicating acute bronchopneumonia.

PATHOLOGIC DISCUSSION

DR. VON HAAM: At the autopsy we found a well-developed, well-nourished young man who weighed about 160 lbs. The external examination of the body revealed nothing particularly abnormal. There was slight cyanosis of the nail beds and some clubbing of the fingers. There was no fluid in either pleural cavity. The right pleural cavity showed dense fibrous adhesions which were separated with difficulty; the left pleural cavity was free. The heart was enlarged, particularly the right ventricle, which measured 1 cm. in thickness as compared to about 4 to 5 mm. in the normal. The leaflets and ostia of all valves were normal. The coronary arteries were patent and not sclerotic.

Each lung weighed approximately 1000 grams. They were voluminous and did not collapse. The right lung showed the fibrous adhesions previously described. There were a few large emphysematous bullae in the margins of the upper and middle lobes. All through the lung parenchyma we found cysts measuring about 1 cm. in diameter and separated by fibrous tissue. The cysts were filled with fluid. We were not exactly sure whether they represented dilated bronchioles or true cysts. The left lung was similar in appearance; there were again some emphysematous bullae at the lung margins and smaller cysts throughout the parenchyma. In addition, nodular areas of consolidation were present which appeared more or less recent. The spleen was moderately enlarged. The liver and all other organs seemed perfectly normal.

Microscopic Examination: The muscle of the right ventricle of the heart appeared markedly hypertrophic. The wall of the pulmonary artery was two-thirds the thickness of the wall of the aorta. The elastic fibers were increased in number and there was some evidence of intimal thickening without atheromatosis. These findings suggested the presence of considerable pulmonary hypertension in the patient. The lung sections showed diffuse alveolar fibrosis with cystic spaces all of which proved to be dilated bronchioles. There was some peribronchial inflammation and recent foci of organizing bronchopneumonia.

In the interpretation of this case I was torn between two diagnoses. At first I did consider this a case of diffuse interstitial pulmonary fibrosis as described by Hamman and Rich, and many histological details fit with their description. However, the many bubble-like dilated bronchioles suggested also a cystic lung which had become repeatedly infected with scar tissue and fibrosis between the cysts. The fibrosis in the lungs looked exactly like the diffuse fibrosis that Dr. Wiseman has mentioned. There was also some exudate present in the bronchioles which seemed to be organizing. Sections of the left lung showed that the patient did suffer from an acute inflammatory process on top of it, as Dr. Wiseman well suggested. The pneumonic lesions were of a peculiar type and showed

more desquamated alveolar cells than leukocytes, which suggested to us the possibility of an atypical or virus pneumonia. It had nothing to do with the chronic lesions of fibrosis and the cysts in the other parts of the lungs. I therefore favor the interpretation of the pulmonary fibrosis as secondary to bronchiolar disease, although I admit that I may not be on too firm ground with my assumption.

Sections through the liver showed that the patient had an acute nutmeg liver with fatty degeneration. The other organs of the patient were histologically normal.

GENERAL DISCUSSION

DR. VON HAAM: I think that Dr. Wiseman hit the diagnosis as close as anybody could and maybe he is more correct than I in his interpretation of the pulmonary fibrosis.

DR. WISEMAN: I have another piece of evidence that I might be right. This man was inducted into the Army during the last World War and they all got chest plates. I think if he had cystic disease of the lung, which is considered congenital, they would not have taken him.

DR. VON HAAM: Cystic lung disease may also be acquired later. Do you think those cysts go with the Hamman-Rich lesion?

DR. WISEMAN: I think you could get retention cysts from fibrosis and choking off of the bronchioles.

DR. J. L. MORTON: Do you treat this condition with cortisone?

DR. WISEMAN: He was treated with cortisone for almost 2 years and it did not improve him. I think cortisone would be contraindicated in a disease like this because there is always a certain amount of secondary infection present which is bound to get worse by this therapy. Thus you will just encourage the spread of the organisms and not be able to do anything for the fibrosis.

DR. RYDER: Clinically this man improved on ACTH. He had come to the point where he was completely free of his dyspnea.

DR. VON HAAM: Subjectively only.

DR. RYDER: That is true. His vital capacity did not change but the man was ambulatory where previously he was wheeled into the hospital unable to move.

DR. WISEMAN: I think cortisone might make him feel better by perhaps breaking up some bronchial spasms. You give patients cortisone and they are going to feel better regardless of what they are suffering from.

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The Story Behind the Word

Some Interesting Origins of Medical Terms

Scar—This is a contraction or corruption of the Latin word "eschara" meaning a scar or a scab caused by burning. This Latin word in turn came from the Greek word "eschara" meaning a hearth or fireplace. Hence carelessness about the fireplace causes scars or scabs from burns.

Elixir—The Arabian words "el eksir" originally designated the philosopher's stone for which the ancient alchemists were searching. Later the medieval alchemists applied this term to a mythical liquor which supposedly conferred immortality upon people. In time the two words "el eksir" were contracted into our single word elixir, which now designates a sweet aromatic alcoholic liquor which serves as a vehicle for soluble medication.

Hernia—This Latin term for a rupture is derived from the Greek word "hernos" meaning a branch, sprout or growth. It was at first used as a slang term in ancient times to designate any unsightly growth or lump on the body which came to view in the public baths. Celsus in about 10 A. D. used the term to designate the protusion of an internal organ and apologized for using a popular or slang term.

Starve—Literally meaning to kill or to die from hunger, this term is derived from the Anglo-Saxon word "steorfan" meaning to die. Closely allied to this is the German word "sterben" which also means to die.

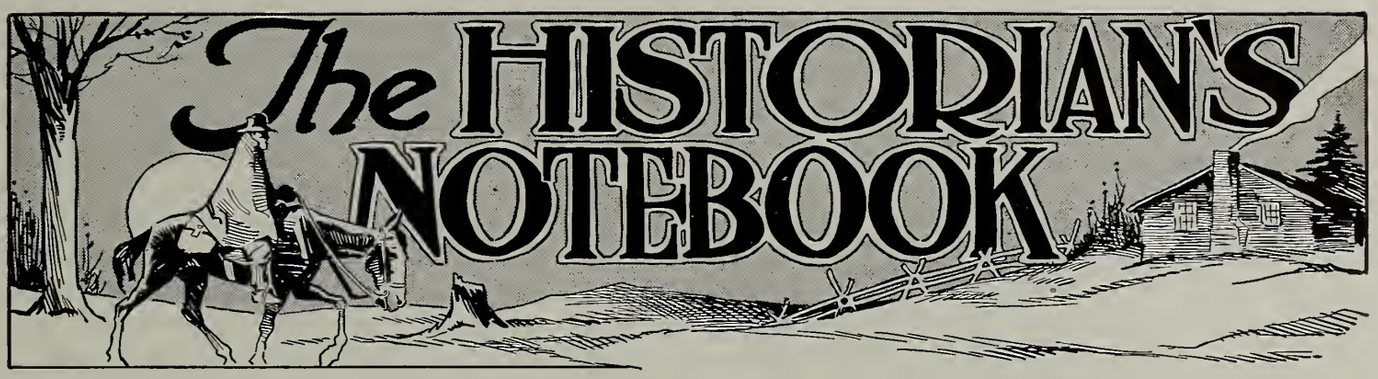
Epidemic—A term literally meaning "upon the people." The word has been used since the time of Hippocrates to designate a disease which occurs suddenly, attacking many people at the same time and in the same city, area or country. The term is composed of the Greek prefix "epi," or upon, and the Greek word "demos," or people.

Enucleate—The Latin word "enucleatus" means "cleared from the husk" and is composed of the Latin "e," or out, plus "nucleus," or nut. Hence to enucleate literally means "to shell out like a nut."

Emesis—Emetic—These ancient Greek words have come down to us almost unchanged and are derived from the Greek word "emeo," I vomit. The term "emesia" was used by Hippocrates to denote vomiting. Emetics are drugs that cause vomiting and a number of these were listed by Celsus in his *De Medicina* in 30 A. D.

Sesamoid Bones—A descriptive term given by Galen to the small flat bones which are found in the tendons of muscles. Their shape reminded him of sesame seeds and hence the name. The name is derived from the Greek "sesame," or seed, plus the suffix "oil or eidos," meaning like.

—HARRY WAIN, M. D., Mansfield, Ohio.



History of the Montgomery County Medical Society 1849-1949

PART I

CURTISS GINN, M. D.

ON the evening of September 13, 1849, in Dayton, Ohio, a group of 14 physicians met to form a county medical society. This first meeting organized the society, elected the officers and the necessary committees and the present Montgomery County Medical Society was launched on its hundred year career.

PROLOGUE

During the 52 years that had elapsed since the coming of the first doctor to this territory—Dr. Jonathan Hole in 1788—there had been at least two previous attempts to form a local society.

In 1811, the first law to regulate the practice of medicine in the State of Ohio was passed by the General Assembly. It divided the State into six districts, according to the location and concentration of the population; each of which was to have three appointed censors whose office it was to examine in theory of practice, materia medica and surgery, the various applicants wishing to practice medicine within the confines of the State. The act also provided for the formation of a local society in each of the districts, and delegates from these were to meet and establish a State Society to meet at Columbus annually.

IN 1803

Considering the times, the State being only newly formed (1803), the low level of most of its citizens socially, and the dislike of all, including the doctors themselves for any regulatory restraint upon their lives and actions, it is remarkable that such an excellent act could have been passed. It stood as the law, with some minor alterations, until 1833. At the time of its passage, only a few doctors in the State were graduates of a regular medical college. Dr. John Steele, coming to Dayton in 1812, was the first. There seems, however, to have been an overabundant supply of healers of the sick, a heterogenous mass, composed of the few graduates, licensees, holders of certificates, faith healers, herb and Indian medicine men with the helpful neighbor in the background.

Because of the paucity of medical schools, a well recognized method of entering the healing art was the preceptorial system whereby the applicant formed an association with a physician already in practice, who need not be a graduate himself, and for the use of the few books available and the knowledge of the secrets of the compounding of drugs, agreed to stay under tutelage for a period of from a few months to as many years. At the end of the appointed time, the preceptor issued to him a certificate entitling the student to practice, with the possible gift of a new suit of clothes or a horse in addition.

After the law of 1811 was enacted, such a certification was not deemed enough and the prospective doctor was required to present himself before a board of censors for examination in the various subjects and if passed was given a license to practice. Although the law provided penalties for nonobservance, it neglected to provide any means for enforcement, so really the only dis-

The Author

● Dr. Ginn, now retired after many years of surgical practice in Dayton, has devoted a considerable amount of time to research in the historical background of medicine in Dayton and Montgomery County.

advantage of noncompliance was an inability to use the courts for the collection of delinquent bills.

MEDICINE A PRECARIOUS LIVING

That practicing medicine was a rather precarious way of making a living is evidenced by the fact that so many of the early doctors resorted to some side line to augment their living, such as farming, lumbering, real estate selling, preaching or in some instances, the keeping of a drugstore. The steady and ever-increasing stream of people passing through the county on their way to the newly opened up territory of Indiana and the farther West was another problem. Many of these had little or no money at the start of the journey and unable to proceed farther would stop in Dayton and set up as doctors, in most cases their only qualification being the preposterous claims as to their ability.

In 1815, the population of the State having greatly increased, a seventh medical licensing district was created, composing Greene and Montgomery and the territories to the north. In compliance with the law, a local society was organized in 1816 with Dayton as the center and meetings to be held Spring and Fall at the time of the licensing. There is no record of any such society meeting after the Fall of 1817.

In 1824, the number of districts was raised to 20, and a second attempt was made to form a local society in each as the basis of creating a State Society. Locally, the group was formed, was attended with quite some success, and Dr. John Steele was sent to Columbus in December of 1827, to take part in the formation of the State Society. There is no record of the local society functioning after 1832, though meetings were held with some regularity up to this time.

M. D.'S VS. APPRENTICES

However, all was not well within the profession. As the number of graduates increased, a strong caste feeling grew up between them and the ones without a diploma. Though the societies did not make any discrimination as to admission, there was enough feeling to prevent any concerted action in medical affairs. This condition, together with the increasing number and the political strength of the sectarians, was sufficient to cause the abrogation of all medical laws under which the State had previously worked. There was no medical practice act in Ohio until an unworkable one passed in 1868. The first really enforceable one was passed in 1895. This is the one under which we still operate.

Even with the chaos existing, meetings of the State Medical Conference were held irregularly from 1835 to 1853. At the meeting of '48, a group of graduates, dissatisfied with things as conducted in the Convention, held a rump meeting and decided to form a new State society which would be more to the liking and more exclusive as to admissions. A charter was secured the same year, and from then on the two societies functioned simultaneously, until the demise of the Conference in 1853.

In national medical circles, a movement was started in 1847, to form a stricter society so far as eligibility was concerned, resulting in the formation of the American Medical Association. The interest in the above proceedings and the fact that the newly organized A. M. A. was scheduled to meet in Cincinnati in 1850, spurred the local members of the profession to again form a society. However, it was admitted as the fifteenth member, although the county ranked third as to wealth and population.

THE 1849 CHOLERA

In the Fall of the year 1849, known as the cholera year, when Dayton numbered but a scant 10,000 people, the following notice appeared in the local newspaper: "The medical men of Dayton will meet at the council chambers on Thursday, September the 13th, for the purpose of forming a medical society." There had been some informal preliminary meetings of men interested prior to this date but at this time the organization was finally organized.

The infant produced was but a puny one—four of the doctors signing up as Godfathers were not present at its birth and indeed took no further notice of it. Of the 14 assisting at its delivery, four were suspended or expelled within the first year and one of the signers of the call to organize was refused membership.

The early meetings were almost wholly given over to questions of ethics, with an occasional paper on the fevers prevailing. The discussions and bickerings over professional ethics may seem like childish quarreling in this day and age. However, a study of the writings and discussions as revealed by the records and minutes brings out a condition that was not understood by the laity and not recognized by all of the physicians themselves.

At a time when education was not widely diffused, the three professions of law, theology and medicine occupied a very high position in the cultural and civic affairs. The leaders felt on account of this position, with its especial privileges, it required an equally high sense of duty, not only to the public but also to themselves, and that when one of their number transgressed the code, it reflected dishonor on them all.

FIRST CODE OF ETHICS

How seriously members of the profession took themselves, may be seen in the first code of the A. M. A. formulated in 1853, adopted by the local society the following year and later published in pamphlet form for distribution to its members, one of the few copies of which, if not the only one in existence, is in the medical library. It consists of 22 pages; it might be noted that while the qualifications and prohibitions for the

doctors themselves has only seven sections, those for the guidance of the treatment of the doctors by the patients runs to ten sections. It is not clear just how patients were to learn of the duties expected of them, but it is all there.

Suspension and expulsion of members was common until after the close of the Civil War; there is no record of any such proceedings since 1888. This last action resulted in a lawsuit filed against the society by the expelled member and finally decided against the defendant. The members would seem to have been much more concerned about the erring member's conduct than their own, since only a few paid the assessment levied against them for the costs of the defense, and the then president, Dr. H. S. Jewett, paid the bill out of his own private funds.

It so happens that in every group a few men motivated by ambition, energy, superior talent or self-interest, take the lead while the remainder follow. That the county society has been no exception is shown by the fact that during the first 60 years of its life, only 20 men occupied the office of president for half of this time and through their influence for most of the remainder.

Of the hundreds of others who have been members, there is lamentably little in the written records, beyond their names. Each played his little part and departed leaving no footprints on the sands of Time.

So in this history, it has seemed best to present the events, proceedings and personalities by decades.

1849-1859

Two Smiths, Edwin the first president, and Edmund the first secretary, were the mainsprings during this period, ably assisted by the two VanTuyls—uncle and nephew. The two Garst brothers, Elias and Michael, Job Haines and Henry K. Steele were also very active in the new society. Meetings were held monthly, usually at the home of one of the members. The essayist for the meetings was arranged alphabetically, and an evening session was favored.

In 1851, charges of unprofessional conduct was brought against three of the small number of members. One was expelled, one allowed to resign, and one cleared of misconduct.

In 1853, a census of the practitioners of the county was made with a view to ascertaining how many would observe the code of ethics, with the following result:

Graduates who are adhering to the code	25
Licensees who are adhering to the code	5
Practitioner (years of practice) who do not adhere to the code	5
Irregular practitioners who do not adhere to the code	24

If this survey does nothing else, at least it gives the number of men practicing medicine at the time and shows the difficulties in establishing a standard of conduct for the local profession. In spite of these results, the code of the A. M. A. was published and distributed to the members.

THE FIRST O. S. M. S. DELEGATE

The year 1853 was marked by two events. The first delegate to the Ohio State Medical Society was appointed with instructions to invite the society to hold its next Annual Meeting in Dayton, which was accepted. The second was the arrival in the city of Dr. J. C. Reeve, who for over three decades was largely to guide the destinies of the local and state profession.

From the time of his coming to his resignation in 1893, there were few years that Dr. Reeve did not hold office in some capacity. An emigrant boy of six years, he had no formal education after leaving home at age twelve, drifting from one means of making a livelihood to another until in his late teens, when he was given a certificate under the preceptorial system then in vogue. He practiced for a few years in a crossroads village in Wisconsin, returning to become a graduate of Western Reserve Medical College. He taught himself French and German, spent two years abroad at the medical centers and came to Dayton to become the most nationally known man that the city had. He was president of the local society five times, of the State Society twice, and for years a translator-reviewer for the foremost medical publications. With the advent of Dr. W. J. Conklin in '69 and Dr. H. S. Jewett in '70, a medical triumvirate was formed, sometimes dubbed "The Holy Trinity," that ruled the society with a firm hand for many years. However, their goal was always a strong and efficient organization.

1856 ANNUAL MEETING

In 1856, the State Society held its Annual Meeting in Dayton—the eighth. It seems to have been a moderate success, though for some undisclosed reason, the local fraternity decided to have a gold medal struck in commemoration of the event and presented to the State, instead of the customary social activities and banquet.

With the advent of Dr. Job Haines as president for the next two years, steps were taken to improve the papers presented at the meetings and the registration of births and deaths in the city was begun.

1859-1869

And now the first and only nonprofessional reference in the society minutes occurs, written in 1860: "The rioting and noise on the streets outside is so great that the meeting is adjourned." However, political interests so dominated the medical one that though the society functioned in a small way until February of 1861, a moratorium was declared and this was the last meeting until four years later.

At the first meeting in January, 1861, Dr.

Reeve had been elected president, but presided at only one meeting. The society members were widely divided on the questions of States' rights and the abolition of slavery, the majority apparently being in favor of the first, though not necessarily the extension of slavery to any new states or territories admitted to the Union. The new president belonged to the "Copper-Heads," the group against the war on the South; he may have been influenced in this by his close friend, Clement Vallandigham, an outspoken advocate of the South, a Dayton lawyer and a problem for the Federal Government, which finally tried to solve the problem by sending him behind the Confederate lines as an undesirable sympathizer. Dr. Reeve and his family, according to some notes his daughter has left, had some uneasy times during this period.

Ten members of the society volunteered for the Service. Dr. McDermott rose to the rank of Lieutenant Colonel, was Surgeon General of the State from 1867 to 1874, and then for a period chief surgeon at the National Soldiers Home here. Henry Steele, Jenner, Weaver, Wise, Geiger, and Berlin are noted, but the names of others have been lost.

On October 11, 1865, Dr. Reeve, who had held over as president from 1861, issued a call for the society to reconvene at the Ludlow Street engine house. In spite of the new doctors that were drifting in, only five members presented themselves. A valuable member was elected in '69, Dr. W. J. Conklin, who possessed a mind and training of a high order.

1869-1879

The increasing population, now some 30,000, drew more and more medical men into the city, some of whom proved to be very valuable additions in the years to come. The last of the three musketeers, Henry S. Jewett, was admitted. He came well prepared by education, having an A. B. as well as a degree in pharmaceutical chemistry, and finally a medical degree from the University of Michigan. He was the only one here who possessed a degree also from the Royal College of Surgeons, following several years' study in the British Isles.

In 1870, an event happened that might well belong to our times. Dr. Thomas Neal, heretofore a quiet and unknown factor, read a paper before the society, entitled "A Plea for State Medicine." It is unfortunate that the discussion that followed has not come down to us; only six members were present however. The position he took on the subject did not seem to have affected his standing among his fellows as he was made president of the society in '73 and '74 as well as again in 1880. In 1872, Dr. Reeve reported the first case of an ovariotomy performed in this county and the last discussion on the therapeutic value of bleeding occupied a session with the members evenly divided on its merits.

THEORY OF ANTISEPSIS

The theory of antisepsis, promulgated by Lord Lister in 1867, seems to have attracted little if any attention, though ether or chloroform anaesthesia was used freely. The earlier doctors were general practitioners first and only an occasional operator, but the number of surgical papers increased during this decade, especially during the latter half. Dr. Reeve demonstrated an instrument for the transfusion of whole blood and Dr. Scheibenzuber, the elder, reported a transfusion that he had performed between a sheep and a dog, but the result was not recorded.

In '75, discussions as to whether it was permissible for a member to consult with a practitioner of the sects—Eclectics and Homeopaths—took up much time, the final conclusion being that if it were committed through ignorance the offense might be overlooked once, but no more.

The sessions of '76 and '77 were peaceful and uneventful, but in 1878, physicians who had been accustomed to having their professional cards displayed in the show window of their favorite druggist, came in for censure and the practice was abolished. To close the decade, the State Society held its thirty-third meeting in Dayton in a two-day successful session. Later in the year, the thirty-second anniversary of the local society was celebrated with a very elaborate banquet all complete with 13 ponderous sounding toasts and a variety of foods and drinks that leaves one aghast in this present time.

1879-1889

Dr. George Goodhue—"Uncle George" to many of the older members—made his initial bow before the society by the recital of a case of cerebro-spinal meningitis, in which he had administered 3015 grains of chloral hydrate within a period of 12 days. The discussion following ranged from observations on the doctor's daring, the possibility of a mistaken diagnosis, and comments on the patient's resistance.

In '84, the report of one successful operation of three performed, brought forth the comment from the then president, Dr. J. M. Weaver, that out of some 500 cases of strangulated hernia passing through his hands as chief surgeon at the National Military Home, none had ever undergone operation.

In 1885, Dr. J. C. Reeve, Jr., entered the fold. He was the only one in Dayton, and indeed one of the very few in the State, to devote himself exclusively to surgery.

In '87, the first case of an acute appendicitis with operation was reported, and the offending appendix shown.

(To be concluded in the November issue)

Hill-Burton Program . . .

Additional Appropriation Brings Ohio's Current Grant Up; Survey of Needs Scheduled; Progress Report on Ohio's 74 Projects Is Given

OHIO will receive an additional $617,192 for the current fiscal year as its share of the expanded Hill-Burton hospital construction program appropriation passed by The Congress this summer, Dr. Ralph E. Dwork, acting director of the Ohio Department of Health, reported.

The amount is earmarked as follows: For rehabilitation centers, $126,498; for diagnostic-treatment centers, $182,098; for nursing homes, $126,498; for hospitals for the chronically ill, $182,098.

The amount is in addition to the previously authorized $3,000,000 for Hill-Burton construction in Ohio for the current fiscal year, which runs from July 1, 1954, through June 30, 1955.

Congress also has voted a substantial appropriation for a survey of present and future needs in the various states. The Hospital Advisory Council will meet in the near future, study needs for such a survey in Ohio and make its recommendations, Dr. Dwork reported.

The expanded Hill-Burton construction program passed by Congress makes available $21,000,000 nationally for the current fiscal year. Congress also voted an appropriation of $2,000,000 for the states studies of future needs.

Congress in 1953 enacted enabling legislation to extend the intent of the Hill-Burton Act through fiscal year 1957 (through June 30, 1957). Actual allotments under that set-up, however, were left to budget appropriations.

The Hospital Facilities Division of the Ohio Department of Health is continuing to approve projects for participation in the Hill-Burton funds in accordance with appropriations available.

There are now 58 projects complete or in use in Ohio, as a result of the Hill-Burton program. Eleven additional projects are under construction, and five are in the planning stage.

Lists containing 51 projects completed and in use have previously been published in *The Journal*. Following are additional projects completed within the past several months:

ADDITIONAL PROJECTS COMPLETED

St. Elizabeth Hospital, Dayton, 176-bed general (addition).

St. Charles Hospital, East Toledo, 201-bed general.

Barberton Citizens Hospital, Barberton, 130-bed general (replacement).

Youngstown South Unit, Youngstown, 187-bed general (addition).

Good Samaritan Hospital, Dayton, 120-bed general (addition).

Barnesville Hospital, Barnesville, 50-bed general.

Bay View Hospital (Osteopathic) Bay Village, 30-bed addition, remodeling.

UNITS UNDER CONSTRUCTION

The following projects are in various stages of construction:

Alliance City Hospital, Alliance, 71-bed general (addition).

People's Hospital, Akron, 172-bed general (addition).

Green Cross Hospital, Cuyahoga Falls, 50-bed general (addition).

St. Elizabeth Hospital, Youngstown, 200-bed general (addition).

Fairview Park Hospital, Cleveland, 188-bed general hospital (replacement—old facility will be renovated and used by Lutheran Hospital).

St. Joseph Riverside Hospital, Warren, 52-bed (addition).

Trumbull Memorial Hospital, Warren, 151-bed (addition).

City Hospital, East Liverpool, 77-bed (addition).

Massillon City Hospital, Massillon, 82-bed (addition).

Marion City Hospital, Marion, 158-bed replacement and health center to house city-county health department.

City Hospital Bellaire, 34-bed general (addition).

IN PLANNING STAGE

The following projects are in the blue print or planning stage.

Southeast Ohio Hospital, Nelsonville; a state owned and operated tuberculosis hospital; bed capacity has been estimated anywhere from 70 to 100, although the proposed unit will mainly be a treatment center for that area of Ohio with emphasis on outpatient treatment and rehabilitation.

Howard M. Hanna Memorial, Cleveland, 91-bed psychiatric unit of University Hospitals; total cost estimated at $2,957,000, of which $500,000 will be Hill-Burton funds.

District Tuberculosis Hospital, Lima; replacement with extensive demolition of older portions and addition will increase capacity from present 125 beds to 158 beds; estimated cost, $900,000.

Lorain Health Center, addition; cost $39,000 of which Hill-Burton plan will furnish $13,000.

Coshocton Memorial Hospital, replacement will increase present 60 beds to 82 beds.



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Proposed Constitutional Amendments . . .

Would Provide for Four-Year Terms for Certain State Officials and For Members of Ohio General Assembly; Arguments For and Against

AT the General Election on November 2, the voters of Ohio will vote on two proposed amendments to the Constitution of Ohio.

One proposal would provide for four-year terms for the office of Governor, Lieutenant Governor, Attorney General, State Auditor, Secretary of State and Treasurer of State and to limit the office of Governor to two successive terms.

The second proposal would provide four-year terms for members of the House of Representatives and the Senate of the Ohio General Assembly.

Many arguments have been advanced, pro and con, on these important proposals. As a public service, and without taking sides, the Ohio Chamber of Commerce has issued a communication, summarizing the arguments for and the arguments against these issues.

The Journal, with the permission of the Ohio Chamber of Commerce, is presenting the arguments herewith, believing that members of the medical profession should have an opportunity to study them in advance of the November 2 election.

The arguments relating to the four-year term for elected state officials, effective in 1959, for all but the State Auditor whose term would be cut to two years, effective January, 1961, and then increased to four years in 1963, making it run concurrently with the terms of other officials, are as follows:

ELECTED STATE OFFICIALS

Arguments For:

Continuity in office is held to be necessary for the orderly development and execution of administration policies. The four-year term would enable a Governor to grasp the problems and institute his policies for their solution, whereas the two-year term merely permits him to begin to become familiar with state issues before he is forced into a new campaign for re-election.

The business functions of the state government are carried on by department heads, in most instances appointed by and responsible to the Governor. Frequent changes of administration, it is contended, lead to the possibility of wholesale change in administrative personnel, with a consequent disruption in service and efficiency.

States, such as New York and Pennsylvania, for many years have had four-year terms for Governor, and it is reported to be the general opinion in these states, that the four-year term has operated to the benefit of the general public in the transaction of state business.

The trend seems to be, in a number of the states, toward extension of the Governor's term, apparently out of the conviction that a reasonable length of tenure is more conducive to efficient administration and to less intrusion of politics.

The same arguments may be advanced as they relate to the offices of Lieutenant Governor, Secretary of State, Attorney General, Treasurer of State, and Auditor. It is said to be an undue burden upon the electorate to require it to pass judgment upon these officeholders every two years. Similarly, the officials themselves are forced by the exigencies of politics to concern themselves more with re-election and less with the business of their office than would be the case if they were assured of more extended tenure.

The four-year term proposal was one of those advanced during the public argument over the question of holding a constitutional convention in Ohio to revise the basic law of the state. The four-year term was frequently set forth as a much-needed improvement in Ohio public affairs.

Arguments Against:

Granted that a four-year term for state officials would permit greater attention to public business, the contention is still valid that adoption of this amendment could simply cement in office for twice as long, an official who proved to be unsatisfactory to the electorate in the administration of his office.

It is argued that rather than to discourage politics at the expense of public administration, the four-year term might operate in an exactly opposite manner. For example, a politically ambitious state official might use the opportunity offered by a four-year term to build up a powerful machine to further his ambitions either for re-election or for further political preferment, thereby reducing to some extent the healthy influence caused by public officials having to go to the voters every two years for a review of their administrations.

It is pointed out that except for the office of Governor, several of the other elective state offices are largely ministerial in nature and exert only an indirect influence upon state policy. The argument can be made, however, that through a four-year term an ambitious official might acquire too much authority in his post to the

detriment of the public interest. Two-year terms provide a check against such possibilities.

The proposal is not consistent with the Ohio tradition by which the people have very jealously circumscribed the powers of the Governor and elected state officers, and have only gradually shown a willingness to extend their authority. While it is true that in modern times the public seems to have entrusted the Governor with enlargement of his powers, the fact is that the political history of Ohio shows that there has long been a hesitancy to permit executive domination of public affairs and a corresponding desire for frequent expression of public opinion at the polls.

MEMBERS OF GENERAL ASSEMBLY

The arguments on the issue as to whether or not members of the General Assembly should serve four-year terms are as follows:

Arguments For:

It is said that an extension from two to four years of terms of state legislators should operate to improve the calibre of men serving in the General Assembly. The office of both Representative and Senator would be much more attractive if a candidate knew that he could hold the office for four years and master state legislative issues and devote himself more thoroughly to the duties of office. Under a two-year term, particularly when the legislator may actually be in Columbus for only a six-month period during a regular session, such advantages are reduced to a marked extent.

The same arguments apply here as in the case of elected state officials—namely, that less time and consideration would have to be given to campaigning for re-election and more time to attending to public business. Those who say that the Legislature has fallen in public esteem in the last half-century contend that the extension of the terms would enhance its standing. This would give it greater dignity in the eyes of the public, and raise it more nearly to a level of prestige and influence with the executive branch of the government.

Legislative issues are growing steadily more complex. They encompass much more than the formerly routine problems of the state, such as the passage of a budget bill, which once occupied the attention of the General Assembly almost exclusively. Today a legislator must devote much study and have access to vast stores of data to pass intelligently upon state questions. A four-year term would enable him to acquire this information and maturity in office.

Arguments Against:

The legislative branch of the government historically and traditionally represents more nearly than any other, the frequently rapid changes and shifts in public opinion. To extend the terms of Representatives and Senators from two to four years would have a tendency to stultify this expression of popular opinion and would make the Assembly a more static branch of government.

The argument that a four-year term is necessary to attract qualified state legislators does not necessarily square with the facts. There are many competent members of the General Assembly, both House and Senate, who are re-elected to office by their constituents for many terms, thus proving the contention that a competent legislator can develop experience through continuity of office under a two-year election system.

While the four-year term proposal for elected state officials was one of the objectives set forth by those supporting the proposal for a constitutional convention in Ohio, only a tentative approval was given in favor of a four-year term of office for the Senate. Furthermore, it was deemed highly doubtful that any change should be made in the two-year term of office of the House. It was pointed out that at least one house of any two-house Legislature needs to be kept as close to the people as possible. Frequent elections are one way to accomplish this. The traditional pattern of a two-year term for members of the House of Representatives is followed by 43 states of the Union. Thirty-two states provide four-year terms for the members of the Senate and only four Southern states (Alabama, Louisiana, Maryland, and Mississippi) provide four-year terms in both houses. (The two-year idea is a tradition in the Federal government where six-year senatorial terms are coupled with two-year terms for all members of the House of Representatives.)

It is contended that neither a four-year nor two-year term of office is in any sense a guarantee of the calibre or quality of an elected representative. A four-year term merely would serve to slow down the process by which competent individuals may be re-elected or unsatisfactory individuals retired from office.

Today's Health Reaches New All-Time High in National Circulation

With the October issue, *Today's Health* will reach a circulation of over 340,000 copies, which is the highest circulation figure in its 31 year history as *Hygeia* or under its present title.

A substantial part of this increase in circulation is due to the diligent efforts of the Woman's Auxiliary to the American Medical Association and their subscription projects at the national, state, and local county level.

Today's Health is now found in the reception rooms of more than 103,000 physicians and 45,000 dentists throughout the United States and possessions. These copies are seen by many thousands of patients every week.

Licenses Granted . . .

All-Time Record of 364 Graduates of Medical Schools Are Authorized To Receive Certificates To Practice Medicine and Surgery in Ohio

A TOTAL of 364 graduates of Schools of Medicine were authorized to receive certificates to practice medicine and surgery in Ohio as a result of the examinations conducted by the State Medical Board in Columbus, June 14-16. Announcement of the list of physicians licensed was made following a meeting of the Board on August 31, by Dr. H. M. Platter, Secretary of the Board.

The group comprised the largest number of doctors of Medicine ever licensed by the Board as the result of the summer examinations, Dr. Platter reported. Contributing largely to the increase was the fact that Ohio State University College of Medicine graduated its first enlarged class in June. There were 135 O. S. U. graduates who took the examinations, compared to an average of between 85 and 90 in previous years. Also the increase in the number of graduates of foreign medical colleges who qualified in the examinations has added to the increase. There were 34 foreign graduates licensed in this group.

The three highest grades in the examinations went to graduates of the University of Cincinnati College of Medicine. Dr. George E. Gorsuch, Cincinnati, was high with an average grade of 90.6 per cent. Two applicants tied for second place with 89.9 per cent each. They are Dr. Richard B. Juergens, Toledo, and Dr. John B. Flege, Jr., Dry Ridge, Ky.

The Board also issued certificates to practice osteopathic medicine and surgery to 70 graduates of osteopathic schools.

In the limited branches, certificates were issued to 48 chiropodists, 2 mechanotherapists, 2 chiropractors, 24 masseurs and 4 cosmetic therapists.

Following is the list of those granted licenses to practice Medicine and Surgery, with the medical school of graduation and residence stated at time of examination:

OHIO STATE UNIVERSITY—Marling L. Abel, Canton; Eli C. Abramson, Toledo; G. Adolph Ackerman, Columbus; John H. Adrain, Lorain; Don M. Alexis, Akron; Alphonse V. Armbruster, Akron; Ralph F. Askam, Jr., Findlay; Norman Atkin, University Heights;

Norman H. Baker, Youngstown; Howard R. Barton, Columbus; Robert E. Batterson, Columbus; James F. Beattie, Columbus; Robert W. Brannon, Columbus; Gill W. Brehm, Columbus; David E. Brown, Jr., Columbus; Harold T. Brown, Crestline; Lauren M. Brown, Kenton; Donald H. Burk, Columbus; Leonard J. Burman, Columbus;

Robert S. Capper, Columbus; Clarence J. Carpenter, Uhrichsville; Richard D. Carr, Columbus; Albert Cohen, Columbus; Edward J. Conrad, Grafton; Richard G. Cotterman, Akron; Lloyd R. Covault, Jr., Orient;

Kenneth A. Delgreco, Cuyahoga Falls; Daniel Desberg, South Euclid; Robert D. Dormire, Sidney; Charles A. Dudgeon, Lima; Richard R. Dysart, Columbus;

Francis W. Eberly, Columbus; Charles H. Eubanks, Jackson; Eugene A. Feldheimer, Canton; Dale B. Flickinger, Jr., Toledo; Richard L. Fodor, Cleveland; David Foxman, Cleveland; Joseph H. French, Columbus; Thomas R. Frye, Columbus; Raymond E. Fuller, Columbus;

John J. Gedert, Jr., Lima; Lee B. Gold, Cleveland Heights; J. Malcolm Graham, Berea; Edward T. Hadder, Jr., Columbus; Louis M. Haley, Dayton; Charles H. Hamilton, Columbus; Charles H. Howarth, Columbus; Dale D. Hubbard, Columbus; Lowell R. Hughes, Delaware;

Paul M. Jackson, Mansfield; John Jacob, Akron; Robert E. Johnson, Perrysburg; Robert E. Johnston, Youngstown; John R. Jones, Toledo;

Eugene W. Kansky, Cleveland; Paul B. Kerr, II, Hicksville; Charles R. Kidd, Lima; Edward W. Kieffer, Toledo; William Kleinman, Glouster; James W. Koenig, Detroit, Mich.; Edmund M. Krigbaum, Columbus; Alex E. Krill, South Euclid; Carl B. Kroeger, Akron;

Donald S. Linton, Jr., East Cleveland; William H. Lippy, Niles; Franklin L. Lyon, Findlay;

James F. McCutcheon, Warren; Wayne L. McFadden, Lima; Philip H. McFarland, Detroit, Mich.; Clare P. McFarren, Cuyahoga Falls; Richard C. McPherson, North Georgetown;

Carl G. Madsen, Jr., Geneva-on-the-Lake; John C. Magill, Columbus; Robert B. Marshall, Pandora; Gerald E. Meerkreebs, Toledo; Russell C. Metzger, Canal Winchester; Don K. Michel, Cuyahoga Falls; John C. Miethke, Miami, Fla.;

Edna S. Miller, Springfield; Bruce E. Mills, Youngstown; Francis E. Moore, Armstrong's Mills; Gerald W. Morris, Vandalia; Joseph J. Mullen, Cleveland; James E. Munger, Columbus;

Harry O. Newland, Columbus; Eileen M. O'Ferrell, Cincinnati; Harold R. Onkst, Greenville; Andrew Opritza, Cuyahoga Falls;

Kathryn Panis, Massillon; Walter G. Parsel, Los Angeles, Calif.; Robert J. Paul, Youngstown; Lawrence J. Peters, Columbus; John L. Phiffer, Columbus; Philip M. Platten, Jr., Lakewood; Frank E. Pollock, Woodsfield; John Kent Pond,

Lima; Robert W. Price, Logan; George W. Priest, Dayton;

James T. Questel, Tallmadge; Robert L. Reinhart, Columbus; Theodore E. Richards, Lima; Don N. Ridgway, Uniontown; Anthony S. Ridolfo, Columbus; Thomas M. Ruskin, Springfield;

Milton J. Sadlon, Cleveland; Paul J. Sauder, Mansfield; Dante G. Scarpelli, Columbus; Robert W. Schmidt, Toledo; Edward S. Schneir, Akron; Donald A. Schutt, Columbus;

John K. Scott, Columbus; Alvin S. Segel, Cleveland; Howard M. Sigal, Youngstown; Thomas E. Simons, Toledo; Norman E. Sindel, Columbus; Jean H. Smelker, Columbus;

Myron R. Smith, Philadelphia, Penna.; Robert G. Smith, Columbus; Gordon B. Snider, Columbus; Harvey J. Snyder, Jr., Akron; John A. Soquel, Jr., Barberton; Roy W. Starkey, Detroit, Mich.; John P. Stevens, Detroit, Mich.;

Nick J. Teteris, Philadelphia, Penna.; Arthur K. Thatcher, Miami, Fla.; David A. Ucker, Columbus; LeMoyne I. Unkefer, Canton;

Albert W. Van Fossen, Columbus; Jack D. Voehringer, Dayton; Joseph C. VonThron, Port Clinton;

Robert J. Wallace, Lakewood; William L. Walter, Miamisburg; Robert E. Whetstone, Lima; Frank L. Zwemer, Lakewood; Thomas Q. Ziegler, Columbus.

UNIVERSITY OF CINCINNATI—William G. Ansley, Cleveland; Robert D. Barber, Cincinnati; Richard K. Bath, Cincinnati; Howard F. Bellamah, Cincinnati; George Benson, Jr., Cincinnati; Kingdon Brady, Cambridge; Allan Brisker, Cincinnati; Richard E. Brown, Cincinnati; William T. Bryan, Jr., Cincinnati;

Denis F. Cash, Cincinnati; Donald E. Chambers, Cincinnati; Bernard T. Cooper, Cincinnati; John F. Daugherty, Independence, Ky.; Joel B. Dennis, Cincinnati;

Paul J. Feder, Cincinnati; John B. Flege, Jr., Dry Ridge, Ky.; Herbert B. Francis, Cincinnati; James Garfield, Cincinnati; Robert H. Gerdsen, Cincinnati; William J. Gerhardt, Cincinnati; Robert R. Gibson, Ferndale, Mich.; Roger G. Giesel, Cincinnati; George E. Gorsuch, Cincinnati; Karl E. Grizzell, Cincinnati;

Jared E. Haight, Cincinnati; Demetreos N. Halikis, Corapolis, Penna.; Alvin L. Heise, Cincinnati; Jay G. Hirsch, Miami, Fla.; Stanley I. Holzberg, Cincinnati; Harold R. Imbus, Dayton;

Edmund L. Jones, Jr., Columbus; Richard B. Juergens, Toledo; Donald R. Kaiser, Cincinnati; William A. Kelly, Cincinnati; Henry J. Kenkel, St. Bernard; Ray E. Kiefhaber, Cincinnati; Thomas J. Klug, Columbus; Robert O. Koehler, Cincinnati; Russell S. Kravetz, Cincinnati;

August H. Lambers, Jr., Cincinnati; Walter J. Lambert, Cincinnati; Richard E. Landis, Flint, Mich.; William P. Levonian, Los Angeles, Calif.; Donald M. Lynn, Jr., Cleveland Heights;

Albert D. McErlane, Cincinnati; Lee McHenry, Cincinnati; Paul D. Mabie, Miami, Fla.; Walter B. Meeker, Troy; Henry P. Meiter, Cincinnati; David L. Miller, Rochester, N. Y.; Ronald E. Moore, Cincinnati;

Yoichi Oikawa, Cincinnati; Melvin L. Olix, Columbus; Lloyd E. Owens, Columbus; Charles K. Perry, Covington, Ky.; Saul H. Polasky, Cincinnati; Robert E. Price, Cincinnati;

Donald I. Radin, Cincinnati; Robert A. Rehm, Columbus; John H. Roads, Cincinnati; William J. Rowe, Cincinnati;

Edward H. Saeks, Cincinnati; Lester W. Sanders, Jr., Cincinnati; Harry F. Schneider, Cincinnati; Jack Schreiber, Canfield; Harold J. Schwendeman, Cincinnati; William M. Serbin, Dayton; James L. Shreffler, Woodville; Ray E. Simendinger, Lebanon;

Louis L. Sommer, Cincinnati; Meredith E. Sorrell, Cincinnati; James P. Stewart, Cincinnati; Jerome Stuhlbarg, Cincinnati; William D. Suer, Cincinnati; Joe Suyemoto, Cincinnati; Edwin Swillinger, Cincinnati; Richard Swillinger, Cincinnati;

Emil P. Taxay, Washington, D. C.; Earl A. Trumble, Cincinnati; Harold L. Unger, Cleveland; Forrest S. Warner, Jr., Cincinnati; George W. Wayman, Bellevue, Ky.; Albert E. Weiss, Toledo; Elmer C. Werner, Cincinnati; James A. Wiseman, Cincinnati; Richard S. Wolf, Cincinnati.

WESTERN RESERVE UNIVERSITY—Lillis F. Altshuller, Cleveland; Robert J. Bailey, Cleveland Heights; Chadwick F. Baxter, Cleveland; John J. Biskind, Shaker Hts.; LaVerne N. Black, Cleveland; Daniel K. Bloomfield, Shaker Heights; John R. Boswell, Cleveland Heights; Richard F. Brailey, Cleveland; Richard A. Braun, Cleveland;

Henry C. Chalfant, East Cleveland; Vera C. Chalfant, East Cleveland; Lawrence A. Coben, University Heights; James H. Demming, Cleveland; Robert W. Dowling, Shaker Heights; Edwin H. Eigner, Cleveland; Elliott F. Ellis, Cleveland;

Margaret E. Faithe, Gayville, S. Dakota; Richard A. Falls, Shaker Heights; James P. Farmer, Cleveland; Lissy Feingold, New York, N. Y.; Lawrence E. Felterman, Shaker Heights; Richard C. Field, Cleveland; Aaron J. Fine, University Heights; James P. Frackelton, Lakewood; Robert M. Frank, Cleveland; Charles H. Fraser, Cleveland Heights; Sanders A. Frye, Jr., Cleveland;

John D. Gerlach, Cleveland; Frank S. Gold, Albany, N. Y.; Norman W. Goldston, Cleveland; Harry E. Goodman, Cleveland; David L. Groshong, Rocky River; Edwin W. Guiney, Cleveland;

John A. Hadden, Jr., Cleveland Heights; Robert A. Hahn, Cleveland Heights; Francis J. Hatch, Euclid; Robert A. Hiatt, Cleveland; Benjamin F. Jackson, Jr., Waterford; Richard K. Jennings, Cleveland;

Allan F. Johnson, Fairview Park; David L.

Jones, Toledo; Frank W. Kiser, Cleveland; Nancy Jean Kowalchick, Cleveland; Gregory B. Krivchenia, Cleveland;

John F. Lane, Hudson; Leslie L. LeMieux, Jr., East Cleveland; Oscar R. Levine, Cleveland; Richard E. Lewis, St. Clairsville; Donald F. Loeffler, Cleveland Heights; Robert W. Loehning, Menasha, Wisc.; Neil W. Love, Cleveland; Lois D. Lyon, Cleveland;

Earl J. Mason, Cleveland; Ruth Matthewson, Nelsonville; David R. Morledge, Billings, Mont.; Paul E. Palmer, East Cleveland; Richard L. Pearse, Cleveland; Herbert E. Pollock, Cleveland; William R. Pudvan, East Cleveland;

Virginia D. Raphael, Cleveland; Frank T. Reynolds, Lakewood; Thomas L. Ring, Cleveland; Michael B. Rothenberg, Cleveland; Joseph R. Rubini, Cleveland Heights; John W. Russell, Cleveland;

Victor Scharf, Cleveland; Edward C. Schott, Cleveland; Anthony F. Sibila, Cleveland; James A. Stanforth, Canton; Kathryn H. Svec, Shaker Heights; Norman E. Swingle, Chagrin Falls;

John R. Trautman, Cleveland; Richard W. Walker, Rocky River; Herbert N. Whanger, Cleveland; Robert B. White, Cleveland; Robert A. Witzeman, West Richfield; Jerry S. Wolkoff, Warren; John A. Woodhams, Cleveland; William R. Young, Cleveland.

OUT-OF-STATE MEDICAL SCHOOLS— Samuel J. Newman, Cincinnati, Cornell Univ.; John F. Condon, Columbus, Creighton Univ.; Euan T. Blanch, Cleveland, Harvard Univ.; Mitchell Karlan, Springfield, Harvard Univ.; Sylvester S. Davis, Jr., Cleveland, Howard Univ.;

Jess F. Bond, Akron, Jefferson Med. College; Nichols Vorys, Lancaster, Jefferson Med. College; Lloyd U. Young, Cleveland, Medical College of Va.; Robert B. Huber, Cincinnati, Northwestern Univ.; Robert O. Jones, Cincinnati, Northwestern Univ.;

Joseph R. Gurnick, Dayton, Stritch Medical School; Joseph A. McCarthy, Toledo, Stritch Medical School; Thomas A. McDermott, Lorain, Stritch Medical School; Roy J. Moser, Jr., Covington, Ky., Stritch Medical School; John J. Murphy, Akron, Stritch Medical School; Edward W. Schnell, Rocky River, Stritch Medical School; Kent K. Scholl, Vandalia, Stritch Medical School; Alfred E. Voigt, Fairborn, Stritch Medical School;

Charles J. Buhrow, Graytown, University of Chicago; Anthony F. Lalli, Akron, University of Chicago; Ronald Teichner, Chicago, University of Illinois; Allen P. Borger, Perrysburg, Univ. of Michigan; John F. McVay, Cuyahoga Falls, University of Rochester; James L. Secrest, Cleveland, Univ. of Rochester;

Morton M. Millman, Cincinnati, Univ. of Washington; Bertram R. Pass, Cincinnati, Univ. of Washington; Robert S. Reeves, Columbiana, McGill University; W. Donald Ross, Cincinnati, Univ. of Manitoba; Eric H. Schmidt, Chatham, Ontario, Canada, Univ. of Toronto; William J. Shine, Milwaukee, Wisc., Stritch Medical School.

FOREIGN GRADUATES — Leopold Chmielewski, Kankakee, Ill., Univ. of Lwow; Peilet P. Horowitz, Forest Hills, N. Y., Univ. of Lwow; Thaddeus Pogorski, Cedar Grove, N. J., Univ. of Warsaw; Victor Iskersky, New York, N. Y., Medical Inst. of Kiev; Wigdor Markiewicz, Cleveland, Univ. of Kharkov;

David Frajndlich, Brooklyn, Univ. of Geneva; D. Frederick Gioia, Louisville, Ky., Univ. of Geneva; Stephen N. Steen, Minneapolis, Minn., Univ. of Geneva; Berdj Harabedian, Cleveland, Univ. of Istanbul; Martin J. Crotty, Detroit, Mich., National Univ. of Ireland; William G. O'Driscoll, Detroit, Mich., Nat. Univ. of Ireland;

Joseph H. Brenner, Cincinnati, Univ. of Liverpool; Ernest R. Wilson, Columbus, Westminster Hosp., London; Arnold Norscher, Brooklyn, N. Y., Univ. of Graz; Dragoljub Jeveremovic, New York, N. Y., Univ. of Paris; Michael L. Michaelis, McConnelsville, Univ. of Erlangen; Ulrich H. Boening, Youngstown, Univ. of Goettingen; Michael A. Matthews, Cincinnati, Univ. of Goettingen;

Heinrich Brinks, Glendale, L. I., N. Y., Univ. of Heidelberg; Luben S. Walchef, Cincinnati, Univ. of Heidelberg; William H. Kern, Denver, Colorado, Univ. of Munich; Gaetano Milazzo, Canton, Univ. of Catania; Americo D'Amico, Fly (Monroe County), Univ. of Naples;

Anthony Garlisi, Mt. Vernon, Univ. of Rome; Lorant Forizs, Butner, N. C., Univ. of Szeged; Vita Draulis, Cleveland, Univ. of Latvia; Verena A. Dzenis, Dayton, Univ. of Latvia; Gvido Jekkals, Fort Steilacoom, Wash., Univ. of Latvia; Victor Straubs, Brooklyn, N. Y., Univ. of Latvia;

Antanas Azelis, Cleveland, Univ. of Kaunas; Jonas Maciulis, Brooklyn, N. Y., Univ. of Kaunas; Alfonsas Martusevicius, Brooklyn, N. Y., Univ. of Kaunas; Juozas Masilionis, Cleveland, Univ. of Kaunas; Felicia Landau, New York, N. Y., Univ. of Cracow.

Dr. Levine of Harvard To Be Guest Lecturer at Cleveland Clinic

Dr. Samuel A. Levine, clinical professor of medicine, Harvard Medical School and Physician at the Peter Bent Brigham Hospital, Boston, will be the fourth annual Physician-in-chief pro tempore on December 16, 17 and 18 at the Bunts Institute of the Cleveland Clinic Foundation. During his tenure, Dr. Levine will devote his entire time to the teaching program of the Fellows in Medicine. A schedule of daily clinics, lectures and seminars has been arranged. Members of the medical profession are cordially invited to attend, Dr. Fay A. LeFevre, acting director of education, announced.

Are You Prepared for November 2?

☆ ☆ ☆

In other words, what do you know about the candidates for public office whose names will appear on the ballot you will receive at the polls on Election Day, November 2?

The officers and Legislative Chairman of your local medical society have secured valuable information on the candidates. See them. Find out how the candidates stand on issues of vital importance to the medical profession. Only an informed voter will be able to cast an intelligent vote.

☆

Here's How One Ohio Congressman Puts the Challenge to Ohio Citizens



☆

Be Sure To Vote

EXTENSION OF REMARKS
OF
HON. J. HARRY McGREGOR
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Tuesday, July 6, 1954

Mr. McGREGOR. Mr. Speaker, a day of decision will be election day, November 2, 1954. It is the duty of every qualified voter to exercise his franchise and prove to the world that Americans value their right to take part directly in the election of Government officials and in the management and control of our Republic. The number of ballots cast will demonstrate to the world how much we value that privilege and will emphasize that the American form of government marches forward with determination, vigor, and strength. Everyone should carefully analyze the candidates to determine whether or not they believe in the philosophy of government that has made America a great Nation. Every candidate should make known his position on the issues confronting us, and also make known his record, both civilian and military. My record, a record of service with a service record basis on which I seek record is public gation

Medical Record of 83rd Congress . . .

Preview of Important Issues Expected in 1955 and Summary of Major Bills of Interest to Physicians Passed or Rejected at Recent Session

WHEN the 84th Congress convenes in January, the Eisenhower Administration will press for passage of at least two bills that failed to get through last session, reinsurance and a new program of medical care for military dependents, according to the Washington Office of the American Medical Association. The former was decisively defeated in the House. The latter did not reach a vote in either chamber.

In a radio address summing up his Administration's legislative achievements, Mr. Eisenhower confirmed that he was prepared to renew the fight next session to have the federal government set up a system for reinsuring health insurance programs.

There have been no indications how far the Administration would go in amending the reinsurance bill to satisfy its critics. It is possible also that if all objectionable features were removed there would be little left of the bill.

At Senate and House hearings, reinsurance was roundly denounced by most witnesses, for a variety of reasons. A. M. A.'s position was that reinsurance wasn't needed because private funds are available for the limited amount of reinsurance that could be used, and that in addition the program projected the federal government too far in the direction of control of medical care.

Although the dependent medical care bill wasn't passed, this fact was not in any way regarded as a defeat for Mr. Eisenhower. The bill was offered in the Senate in plenty of time for action, but the introduction of the House bill was held up until Defense Department could estimate the first year's cost, eventually set at $67 million. At any rate, neither Senate nor House Armed Services Committee held hearings on the measure.

In another statement, Mr. Eisenhower made it clear that he expects the next Congress to do something about improving and making more uniform the system of medical care for servicemen's families. Congress, he said, "must eventually meet certain imperative needs of the members of the armed forces." He explained that servicemen now "lack adequate medical care for dependents. . . . It is most important that these needs of the armed forces personnel serving their country often in remote corners of the world engage our serious consideration."

DIFFERENT POINTS OF VIEW

Although the American Medical Association has not had an opportunity to testify on the dependent care plan before Congressional committees, it has made its views known to the Defense Department. In general the A. M. A. is not opposed to Defense Department proposals that a more uniform system be worked out, and that the federal government bear most of the cost. On one important point, however, the recommendations of the department and of the Association are in direct conflict: The department would have the military medical departments themselves furnish dependent medical care wherever they could, with service families going to private physicians and private hospitals only where the uniformed physicians couldn't handle them. The Association, on the other hand, proposes that dependents be cared for by the military medical departments only where civilian medical facilities are inadequate to furnish proper care.

Federal officials, meanwhile, are busy preparing to put into effect the new health bills passed by the 83rd Congress, which from the standpoint of the medical profession, was a very active Congress. During the two sessions, 16,470 bills and resolutions were introduced, of which 407 were of interest to the medical profession.

ADMINISTRATION HEALTH PROGRAM

The Eisenhower health program, built on the philosophy that human problems are an important concern of the government, was unveiled in a series of January messages to Congress. Although 1953 saw an occasional Administration recommendation on health and social legislation, it was not until the State of the Union Message of January 7, 1954, that the Administration's views on medical and health bills began to unfold.

The President proposed legislation to extend the social security program to an additional 10,000,000 persons (including physicians); an improved and broadened vocational rehabilitation program with a goal of rehabilitating 200,000 persons annually within five years; an expansion of the Hill-Burton Hospital Construction Act; a streamlining of Public Health Service grants; and the establishment of a $25,000,000 fund to reinsure private insurance companies against losses on health policies.

The A. M. A. supported the stated objectives of the President's health message, but objected to the reinsurance proposal, and in the social security bill, to the inclusion of doctors and the waiver of premium feature. Bills to carry out the President's program were introduced. After

extensive hearings, the following major laws were enacted:

Social Security: Revised to extend coverage, increase benefits and taxes, liberalize the retirement test, and maintain benefit levels for the disabled. Congress declined to include physicians under the compulsory coverage feature of the law, but the President's recommendation on the method of waiving OASI premiums for the permanently disabled was adopted. A. M. A.'s alternate plan was to count the ten best years in determining pensions. This virtually would have eliminated the need for medical determination.

Hill-Burton: The 1946 Hill-Burton Hospital Construction Act was expanded to permit the federal government to spend $182,000,000 in three years to help finance the construction of new non-profit health facilities. In 1953, the Congress extended the life of the regular Hill-Burton Act to 1960.

Vocational Rehabilitation: The new law gives states more assistance and responsibility for rehabilitation programs in an attempt to increase from 60,000 to 200,000 by 1959 the number of disabled persons rehabilitated yearly. It also provides for special training for rehabilitation specialists, increased research on conditions that result in handicaps, and new benefits for the blind.

However, as stated, Congress declined to enact the health reinsurance proposal, regarded by the Administration as the keystone of the health program.

The Administration bill to streamline Public Health Service grants was passed by the House but failed in the Senate to progress beyond the hearing stage.

In completely rewriting the federal tax laws for the first time in 75 years, Congress lowered the medical expense tax deduction from 5 per cent to 3 per cent, doubled the maximum limitation on deductions, and liberalized other health and drug tax features.

Congress declined to act upon: (a) A number of bills to make it a presumption that certain diseases were incurred from a veteran's military service, rather than upon a scientific basis; (b) bills to permit self-employed persons to take tax deductions for their personal pension annuities; (c) legislation to offer free medical care to the dependents of military personnel; and (d) a bill to permit the federal government to contribute with its employees in purchasing health insurance.

In summary, of the 407 measures of medical interest in the 83rd Congress, the following became public law:

Fireworks ban; Transfer of Indian hospitals to Public Health Service; Creating Commisison on Organization of Executive Branch (Hoover); Hospital Construction Act amendments; Establishment of Department of Health, Education, and Welfare; Establishing Commission on Intergovernmental Relations; Western states compact for higher education; Doctor draft amendments;

Federal charter for National Fund for Medical Education; Factory inspection by Food and Drug agents; Presumption of service-connection for tuberculosis; Eliminating medical supervision of Army food preparation; Broadening the Vocational Rehabilitation Act;

Creating National Mental Health Week; Aid to Philippines for veterans; Medical expense tax deductions; Permitting oral narcotic prescriptions; Social security amendments; Life insurance for federal employees; and amending Unemployment Compensation Act.

H Series Government Bonds Make Ideal "Carefree" Investment

Ohio physicians who would like to invest their surplus cash at a good conservative rate of interest and maximum security of investment will be interested in the relatively new addition to the U. S. Treasury savings bond portfolio—the Series "H" Savings Bond.

These new "H" Bonds are rapidly growing in popularity among those who look to the future safety of their investments, but who, at the same time, want a regular source of income from their savings.

Series H Bonds pay current income by semiannual interest checks to provide an investment yield of 3 per cent per annum, compounded semiannually if held to maturity.

They are priced at par and are sold in convenient investing denominations of $500, $1,000, $5,000 and $10,000. They can be purchased by individuals or by two co-purchasers and may be redeemed at par after six months.

Here is how interest is paid per $1,000 bond if investor elects to receive check every six months: First check, $4.00; next seven semiannual checks, $12.50 each; next 11 semiannual checks, $17.00 each; final check at maturity (9 years, 8 months), $17.00; total, $295.50.

Here are points to be considered about the H Bond Series:

They are safe—backed by the full credit of the U. S. Government.

They may be redeemed at par after six months from issue date, on one month's notice.

They are not subject to the risks of market fluctuations.

They are exempt from state and local income taxes.

Investor receives a U. S. Treasury interest check every six months.

Investment yield is 3 per cent when held to maturity.

They are among the ideal "carefree" investments.

Physicians are advised to consult their local bankers for additional information and advice.

Medical Education . . .

With Number of Doctors at 220,100, a Record Ratio of Doctors to Population Has Been Established, A. M. A. Annual Report Indicates

A RECORD ratio of one doctor for every 730 persons in the United States has been reached during the past year through the graduation of the largest class of physicians in history and the continued expansion of the nation's medical schools.

The ratio will be lowered even more in the next few years as the number of medical graduates is expected to rise more rapidly than the general population.

The record graduation of 6,861 doctors during 1953-1954 brings the nation's physician population to approximately 220,100.

This record graduation was announced in the 54th annual report on medical education in the United States by the American Medical Association, which appeared in the September 11 issue of *The Journal of the A. M. A.* Highlights of the report are:

The enrollment of 28,227 is the greatest number of students in medical education in the history of this country.

The freshman class enrollment of 7,449 also is a record.

Of the freshmen entering medical schools, 68.9 per cent had "B" averages in their pre-medical training, 21.1 per cent had "A" averages and 10.0 per cent "C."

Only 5.1 per cent of the freshmen left medical school because of academic failures or for other reasons in comparison to a 9.5 per cent rate 15 years ago.

Ten new four-year medical schools are in the construction or planning stage and will be in operation within the next five to six years.

More than 76 million dollars was spent during 1953-1954 for new facilities, remodeling or completion of buildings for medical instruction.

The budgets for the medical schools during 1954-1955 total more than 143 million dollars.

There were 21,328 physicians who did volunteer teaching without pay during the year to aid in educating medical students throughout the nation.

OHIO'S COLLEGES

Ohio medical colleges graduated 310 Doctors of Medicine as follows: University of Cincinnati College of Medicine, 89; Western Reserve University School of Medicine, 85; Ohio State University College of Medicine, 136.

Ohio's ratio of freshman medical students to 100,000 of state population was exactly the same as the average for the nation, 4.7. The average is based on the number of Ohio freshman students in all medical colleges, regardless of whether they are in Ohio. The ratio in other states varied from 1.7 in New Mexico (which has no medical college) to 7.9 per cent in Nebraska.

The ten new four-year medical schools will be at the Universities of California, Mississippi, Miami, Missouri, Florida, Kentucky, West Virginia, North Dakota, and Yeshiva University of New York and Seton Hall University. In addition, three other medical schools are being considered.

The report stated that the loss of fewer students through academic failure or withdrawals could not be attributed to "any specific cause with complete certainty."

However, the report added it is reasonable to assume that this must be due in part to improved selection methods by each school's examining committee and the "greatly intensified efforts in the area of student guidance and counseling."

Perhaps the most interesting fact concerning loss of students was that only two seniors failed out of the 6,475 enrolled in medical schools this year.

Besides the 28,227 medical students training in the nation's 80 approved medical schools, there were 59,430 persons receiving some type of instruction from medical school faculties. These included dental, pharmacy and nursing students, student technicians, physicians taking continuation courses or basic science courses for specialty training, physicians with fellowship appointments, interns, resident doctors, and physicians seeking advanced degrees.

INTRAMURAL TEACHING IN OHIO

Ohio's medical schools showed the following intramural teaching responsibilities:

Ohio State University College of Medicine—dental students, 575; pharmacy students, 24; nursing students, 336; student technicians, 223; arts and science students, 1,160; interns, 30; residents, 117; other graduate students in basic medical sciences, 162; total, 2,627.

University of Cincinnati College of Medicine—Nursing students, 124; student technicians, 3; arts and science students, 2; physicians in continuation courses, 521; physicians with fellowship appointments, 31; interns, 52; residents, 122; physicians seeking advanced degrees, 35; other graduate students in basic medical sciences, 9; total, 899.

Western Reserve University School of Medi-

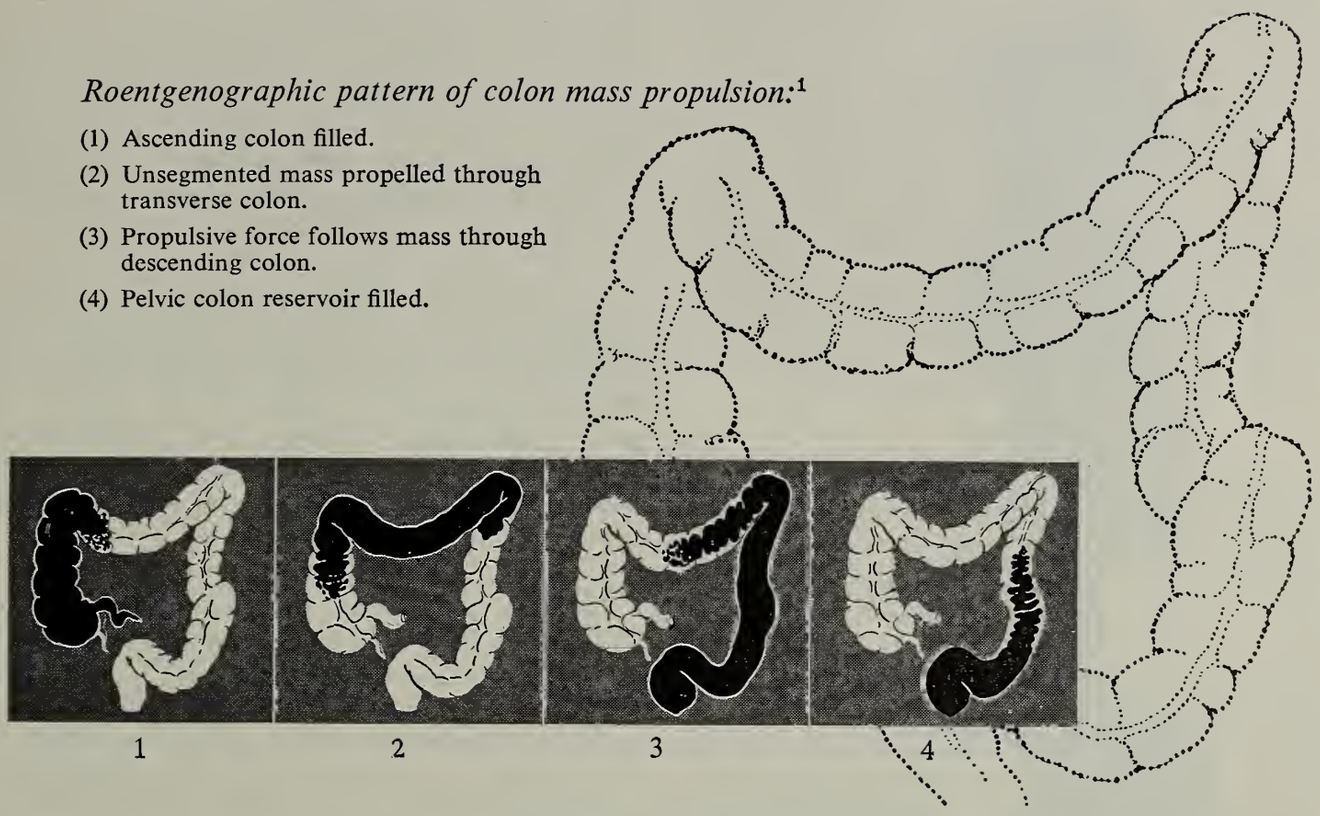
Roentgenographic pattern of colon mass propulsion:[1]

(1) Ascending colon filled.

(2) Unsegmented mass propelled through transverse colon.

(3) Propulsive force follows mass through descending colon.

(4) Pelvic colon reservoir filled.



Reestablishing Bowel Reflexes with Metamucil®

Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.[2]

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of Plantago ovata) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Factors Contributing to Chronic Constipation

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.[2]

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

Dosage Considerations

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

cine—Dental students, 179; nursing students, 198; student technicians, 14; arts and science students, 7; physicians in continuation courses, 84; physicians taking basic science courses for specialty boards, 50; physicians with fellowship appointments, 39; other graduate students in basic medical sciences, 33; total, 604.

In order to maintain high levels of instruction, 28,435 faculty personnel were needed in the 80 medical schools during last year. And 21,328 of these faculty members volunteered to teach without pay, their duties varying from a few hours annually to large areas of responsibility.

FINANCING

In regard to the costs of medical education the report said that "in spite of augmented funds available to medical schools these institutions continue to face difficult and perplexing problems." In summarization the report added:

"The adequate maintenance of currently existing and newly developing medical schools, together with the constant demand for the application of new knowledge and techniques in the interest of ever better medical care for the American public, implies a continuing need for augmented financing of medical education and research."

American College of Surgeons Section Meeting Scheduled in Cleveland

The American College of Surgeons has made a preliminary announcement of its sectional meetings, one of which will be held in Cleveland, February 21-24, at Hotels Cleveland and Hollenden.

The four-day meeting is being developed by Dr. Stanley O. Hoerr and his committee. A program of unusually high merit will be presented, in general surgery and the surgical specialties. Specialty programs are under the supervision of Dr. Lorand V. Johnson, ophthalmology; Dr. Wilbert H. McGaw, orthopedic surgery; Dr. Fred W. Dixon, otolaryngology; Dr. Earle B. Kay, thoracic surgery; and Dr. George Austen, Jr., urology.

Clinics will be held at St. Luke's Hospital, University Hospitals, Mt. Sinai Hospital, Cleveland Clinic, Lakeside Hospital, City Hospital.

Two new features will be added to this year's four-day meeting: A program of short papers on research problems selected from the Forum on Fundamental Surgical Problems, presented at the 1954 Clinical Congress, and a special program for nurses and hospital personnel. Cooperating in the program for nurses are the Ohio Hospital Association, the American Hospital Association, the National League for Nursing, and the Ohio State Nurses Association. Nurses, surgeons and anesthesiologists will participate in this program.

Do You Know? . . .

The 27th annual Graduate Fortnight of the New York Academy of Medicine is scheduled for Octobr 18 through 29. The theme is "Infections and Their Management." Additional information may be obtained from the Committee on Medical Education, New York Academy of Medicine, 2 East 103rd St., New York, N. Y.

* * *

Dr. Albert B. Sabin, professor of research pediatrics at the University of Cincinnati, spoke before the third International Poliomyelitis Conference September 8 in Rome, Italy, on the subject, "Avirulent Viruses for Immunization Against Poliomyelitis." He was accompanied by two members of his staff, Dr. M. Ramos Alvarez and Dr. Robert M. Chanock.

* * *

Dr. Rex H. Wilson, medical director of the B. F. Goodrich Company, Akron, participated in the 11th International Congress on Industrial Medicine in Naples, Italy, by presenting a paper entitled, "Toxicology of Plastics and Rubber." Dr. Wilson is a member of the Committee on Industrial Health of the Ohio State Medical Association.

* * *

Dr. Herman J. Bearzy, director of the Department of Physical Medicine and Rehabilitation at Miami Valley Hospital, Dayton, described the use of ultrasonic therapy in treatment of patients with torticollis before a meeting of the American Institute of Ultrasonics in Medicine in Washington, D. C.

* * *

Approximately 35 pairs of twins from 19 states and from Canada responded to a recent nationwide appeal for indentical twins, one or both of whom are afflicted with multiple sclerosis. The appeal is continuing and volunteers are asked to contact The National Multiple Sclerosis Society, 270 Park Ave., New York 17, N. Y.

* * *

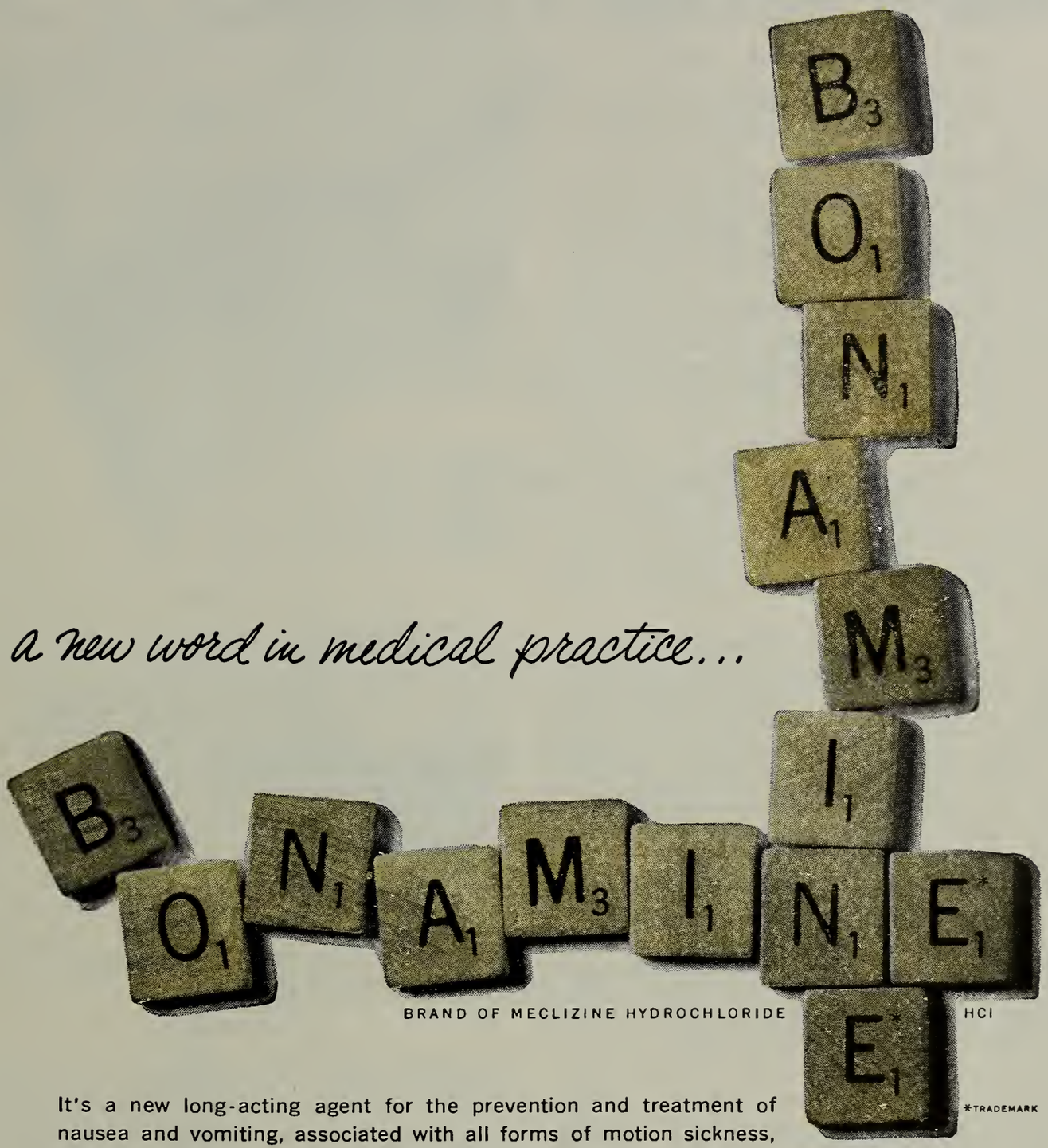
The *Cleveland Press* reported that the first school in Ohio to train medical record technicians opened at Marymount Hospital in Cleveland in September.

* * *

On August 22 the pediatricians of Summit County organized the Akron Pediatric Society. The following officers were elected: Dr. Joseph M. Ulrich, president; Dr. L. E. Rector, vice-president; and Dr. Max E. Griffin, secretary-treasurer.

* * *

Trustees of the American Hospital Association have given the green light to construction of a new five million dollar headquarters building in Chicago on land offered by Northwestern University. The proposed 26-story building will front on Lake Shore Drive adjacent to the campus.



It's a new long-acting agent for the prevention and treatment of nausea and vomiting, associated with all forms of motion sickness, radiation therapy, vestibular and labyrinthine disturbances, and Ménière's syndrome.

Side effects, so often associated with the use of earlier remedies, are minimal with Bonamine. Its duration of action is so prolonged that often a single daily dose is sufficient. Bonamine is supplied in scored, tasteless 25 mg. tablets, boxes of eight individually foil-wrapped and bottles of 100.



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Division, Chas. Pfizer & Co., Inc.

Medical Education Foundation . . .

Nearly $7 Million Already Contributed to Medical Schools—Half from Doctors; Chairmen of County Committees for Campaign Are Named

EVERY Ohio physician will again have an opportunity this Fall to support the nation's medical schools by contributing to the 1954 campaign of the American Medical Education Foundation.

The A. M. E. F. was founded by the American Medical Association in 1951 to stimulate the medical profession toward assisting medical schools to overcome serious financial difficulties and maintain high standards of medical education. The National Fund for Medical Education also was organized to seek support primarily from business and industry.

Since 1951, a total of $6,941,157.58 has been distributed to the 80 medical schools, of which about 50 per cent was donated by the medical profession.

Dr. William M. Skipp, Youngstown, is chairman of the Ohio A. M. E. F. Campaign Committee, which is composed of the 11 District Councilors of the Ohio State Medical Association. The councilors have appointed county chairmen in their respective districts after consultation with the local medical society presidents.

The initial appeal to support the Foundation will be in the form of a letter from Dr. Merrill D. Prugh, President of the State Association, to be followed-up locally by the county chairmen.

During 1953, a total of 2,631 Ohio physicians made financial contributions to medical schools. Of that number, 542 contributed $25,958 through A. M. E. F., and 2,089 donated $103,066. 67 directly to their own medical schools. Comparable figures for the entire country in 1953 were: 18,176 physicians gave $1,089,962 through A. M. E. F., and 29,132 physicians donated $1,369,137 to their own medical schools.

The Ohio A. M. E. F. Campaign is not meant to be in competition with the Alumni Funds and other fund-raising efforts of individual medical schools. The Ohio Committee hopes that physicians who have elected to support medical education through that method will continue to do so. Gifts through the Foundation may be designated for a particular school, and such gifts will be added to the school's basic grant from the unearmarked funds.

Ohio contributors to the American Medical Education Foundation increased from 152 in 1951 to 265 in 1952 and 542 in 1953. Dr. Skipp and the members of his Committee are hopeful that the 1954 record will show even more improvement, and that many more Ohio physicians will rally to the support of medical education.

Following is a list of the county chairmen for the 1954 A. M. E. F. Campaign:

FIRST DISTRICT

ADAMS—Kurt E. Platschik, Manchester
BROWN—Donald L. Domer, Georgetown
BUTLER—Clyde G. Chamberlin, Hamilton
CLERMONT—O. C. Davison, Bethel
CLINTON—Nathan S. Hale, Wilmington
HAMILTON—Stanley W. Whitehouse, Cincinnati
HIGHLAND—Clifford G. Foor, Hillsboro
WARREN—Frank L. H. Batsche, Mason

SECOND DISTRICT

CHAMPAIGN—F. E. Lowry, Urbana
CLARK—Paul W. Schanher, Springfield
DARKE—A. E. Hollenberg, Hollansburg
GREENE—Ray W. Barry, Xenia
MIAMI—William T. Wilkins, Jr., Piqua
MONTGOMERY—Harold M. James, Dayton
PREBLE—C. E. McKinley, Camden
SHELBY—George J. Schroer, Sidney

THIRD DISTRICT

ALLEN—Ralph R. Snowball, Lima
AUGLAIZE—D. W. Nielsen, Waynesfie'd
CRAWFORD—Wilbur G. Carlisle, Bucyrus
HANCOCK—Donald R. Brumley, Findlay
HARDIN—Robert H. Zeis, Kenton
LOGAN—Clyde K. Startzman, Bellefontaine
MARION—A. M. Mogg, Marion
MERCER—M. G. Harnick, Coldwater
SENECA—Paul J. Leahy, Tiffin
VAN WERT—R. H. Good, Van Wert
WYANDOT—T. R. Huston, Carey

FOURTH DISTRICT

DEFIANCE—Richard A. Cunningham, Defiance
FULTON—C. F. Murbach, Archbold
HENRY—Robert J. Blough, Deshler
LUCAS—Maurice A. Schnitker, Toledo
OTTAWA—C. R. Wood, Port Clinton
PAULDING—Ray H. Mouser, Paulding
PUTNAM—Arthur P. Daniel, Ottawa
SANDUSKY—Leo A. Pokerr, Fremont
WILLIAMS—Paul G. Meckstroth, Bryan
WOOD—H. W. Dierksheide, Pemberville

FIFTH DISTRICT

ASHTABULA—Frank Veroni, Ashtabula
CUYAHOGA—Clifford J. Vogt, Cleveland
GEAUGA—S. Hayashi, Chesterland
LAKE—Alfred C. Mahan, Willoughby

SIXTH DISTRICT

COLUMBIANA—Chester W. Dewalt, Columbiana
MAHONING—Wm. M. Skipp, Youngstown
PORTAGE—Robert M. Dumm, Kent
STARK—J. E. Purdy, Canton
SUMMIT—A. M. Weil, Akron
TRUMBULL—C. A. Anderson, Warren

SEVENTH DISTRICT

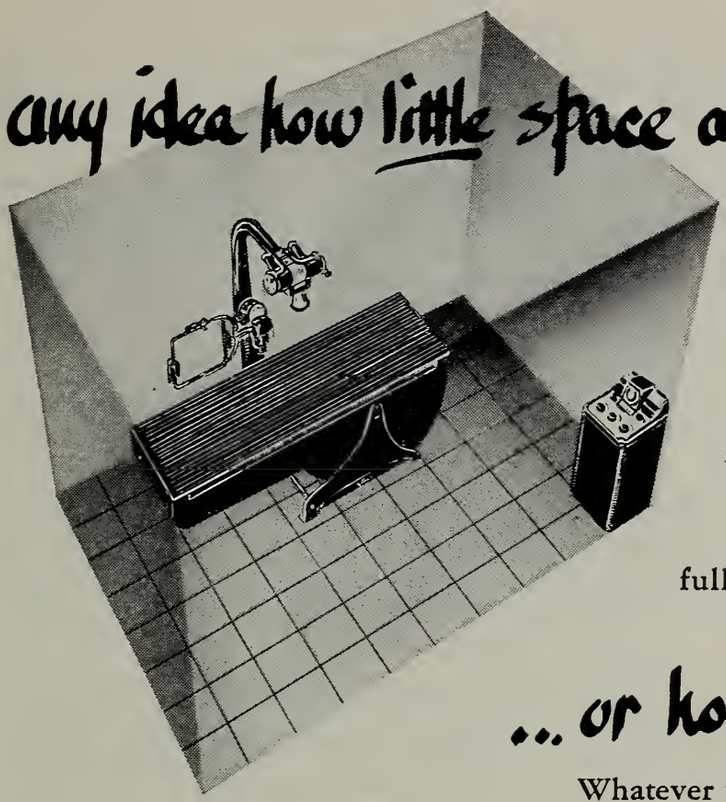
BELMONT—Harry G. Harris, Martins Ferry
CARROLL—Carl A. Lincke, Carrollton
COSHOCTON—G. A. Foster, Coshocton
HARRISON—G. E. Henderson, New Athens
JEFFERSON—Jacob Mervis, Steubenville
MONROE—A. R. Burkhart, Woodsfield
TUSCARAWAS—Harold F. Wherley, New Philadelphia

EIGHTH DISTRICT

ATHENS—E. L. Schmidt, Athens
FAIRFIELD—William S. Jasper, Pleasantville
GUERNSEY—James A. L. Toland, Cambridge
LICKING—P. N. Montalto, Newark
MORGAN—Henry Bachman, Malto
MUSKINGUM—Donald A. Urban, Zanesville
NOBLE—Edward G. Ditch, Caldwell
PERRY—O. D. Ball, New Lexington
WASHINGTON—Donald S. Williams, Marietta

(Continued on page 972)

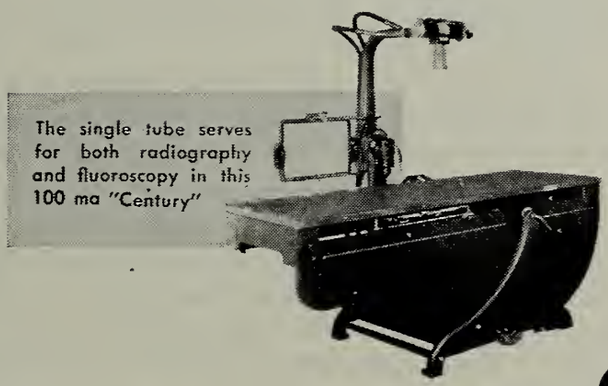
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See how comfortably a single-tube "Century" (with full size 76" table) fits in an 8' x 10' room. No wasted space behind the table for floor rails and tubestand supports. All manipulation (even changeover from radiography to fluoroscopy) can be done from the *front* of the table so you need never go behind it. Despite its compactness you have at command a full range of radiographic and fluoroscopic resources.

... or how versatile it is?

Whatever your x-ray need there is a "Century" combination to meet it *exactly* . . . neither more nor less.



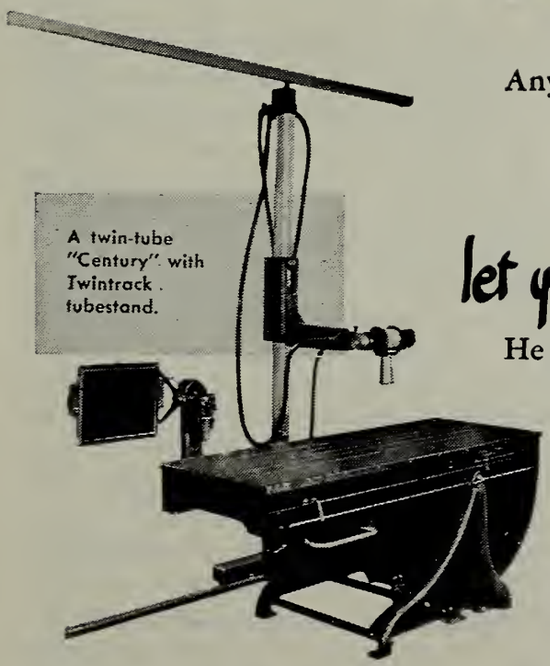
The single tube serves for both radiography and fluoroscopy in this 100 ma "Century"

for example, you can choose among:

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Any way you look at it . . . moderate first cost, modest maintenance, or high trade-in . . . a Picker "Century" is a fine buy. Nothing flimsy about it; it's built to last.



A twin-tube "Century" with Twintrack tubestand.

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He can tell you, too, about the Picker Rental Plan which will put a "Century" in your office without initial capital investment.

the PICKER "Century"

combination radiographic-fluoroscopic x-ray unit

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CINCINNATI 11, OHIO, 4271 Harrison Avenue
COLUMBUS 1, OHIO, 1202 Forsythe Avenue
TOLEDO 7, OHIO, 844 Sawyer Road
CANTON, OHIO, 2435 41st Street
DAYTON, OHIO, 2147 Auburn Avenue

NINTH DISTRICT

GALLIA—Leo C. Bean, Gallipolis
HOCKING—O. F. Yaw, Logan
JACKSON—William T. Washam, Jackson
LAWRENCE—G. G. Hunter, Ironton
MEIGS—Roger P. Daniels, Pomeroy
PIKE—G. W. Cooper, Piketon
SCIOTO—William J. Hartlage, Sciotoville
VINTON—H. D. Chamberlain, McArthur

TENTH DISTRICT

DELAWARE—J. G. Parker, Delaware
FAYETTE—J. M. Herbert, Washington C. H.
FRANKLIN—Richard L. Meiling, Columbus
KNOX—Robert H. Hoecker, Mt. Vernon
MADISON—J. W. Hurt, West Jefferson
MORROW—William Lowell Murphy, Cardington
PICKAWAY—Jasper M. Hedges, Circleville
ROSS—W. M. Garrett, Chillicothe
UNION—R. B. Butler, Marysville

ELEVENTH DISTRICT

ASHLAND—Howard R. Wetzel, Ashland
ERIE—Dean E. Sheldon, Sandusky
HOLMES—Neven P. Stauffer, Millersburg
HURON—George F. Linn, Norwalk
LORAIN—Joseph M. Strong, Elyria
MEDINA—Arthur F. Wolf, Seville
RICHLAND—Max D. Garber, Mansfield
WAYNE—F. C. Ganyard, Wooster

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since August 6, 1954. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

BELMONT COUNTY
Fred Wm. Cook, Jr., Martins Ferry

CUYAHOGA COUNTY
Jeanne E. Andrews, Cleveland
Veo L. Beck, Cleveland
Edward J. Bishop, Cleveland
Merton E. Burhans, Cleveland
Robert Ellis, Cleveland
Benjamin Farah, Lakewood
Lelabelle Freeman, Cleveland
Ferenc M. Frieman, Cleveland
Ilona L. Kasa, Cleveland
Philip J. Landsman, Cleveland
David S. Leighninger, Cleveland
Witold G. Lewicki, Cleveland
Franklin R. Shaft, Cleveland
Filmore Schiller, Cleveland
Roland E. Schneckloth, Cleveland
Selig S. Strassman, Cleveland
Leif George Suhrland, Cleveland
Edward Tennen, Cleveland

ERIE COUNTY
Gene M. Thompson, Huron

FULTON COUNTY
Robert A. Gerrich, Delta

JEFFERSON COUNTY
William B. Mikita, Steubenville

LUCAS COUNTY
Arthur K. Bell, Toledo
Gerald Stark, Toledo

MEDINA COUNTY
Donald Pinkerton, Lodi

PIKE COUNTY
William D. Shidal, Waverly
Morgan E. Wing, Waverly

WAYNE COUNTY
Morris S. Dixon, Jr., Wooster

Obstetrics and Gynecology Examinations Scheduled

The American Board of Obstetrics and Gynecology has announced its next scheduled examination (Part I), written and review of case histories, for all candidates will be held in various cities of the U. S., Canada, and military centers outside the continental United States, on Friday, February 4, 1955. Additional information may be obtained from the Secretary, Dr. Robert L. Faulkner, 2105 Edelbert Rd., Cleveland 6, Ohio.

What To Write For

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

Health Today. Published by the American Medical Association. Discusses highlights of health progress over the past 50 years. For distribution to the public. Good for county fairs and other gatherings; doctors' waiting rooms, and as an enclosure with billings to patients. Available in quantities without charge from the Ohio State Medical Association, 79 E. State Street, Columbus 15.

Physician in the Courtroom. This is Volume 1 in a Law-Medicine Series being published by the Law-Medicine Center of Western Reserve University, a cooperative program of the School of Law, School of Medicine, Institute of Pathology, and the Cuyahoga County Coroners Office and Laboratory. This volume covers "Injury and Cancer," "Medical Ethics and the Law," "Expert Medical Testimony and the Medical Expert," and "Trauma and Heart Disease." Available from The Press of Western Reserve University, Cleveland, Ohio.

How to Get a Doctor. Article in May, 1954 *Farm Journal*, reporting tried and tested methods of attracting physicians to small towns and rural areas. Reprints available from Public Relations Department, American Medical Association, Chicago, 10.

A Look at Modern Health Insurance. A new book, containing brief history of voluntary health insurance; a review of the nation's health record; basic principles of health insurance; Blue Cross and Blue Shield developments, and other authentic information. Available for $1.50 from the U. S. Chamber of Commerce, 1615 H. Street, N. W., Washington 6, D. C.

Mobilizing Your Personnel Resources for Better Patient Care. Published by the Office of Defense Mobilization for hospital administrators, this booklet describes "ways to increase the productivity of hospital personnel." Designed to assist meeting added strain on supply of health personnel in case of emergency. Available for forty cents from Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Guiding Principles of Occupational Medicine—Published by the Council on Industrial Health of the American Medical Association, this booklet is must reading for physicians who do industrial medicine. Concisely stated in six readable pages. Obtain from Council on Industrial Health, American Medical Association, 535 North Dearborn St., Chicago 10.

Postgraduate Programs . . .

A Number of Excellent Courses Have Been Added Since Last Month's Announcements; Physicians Are Offered Wide Selection Over State

A NUMBER of excellent postgraduate courses have been announced adding to the list of fall programs available to Ohio physicians throughout the State this fall. The September issue of *The Journal* listed a number of programs that had been announced at that time. Several of these programs were held in September, but many more are still in the future. Others have been announced since that issue went to press.

Following are the courses scheduled in the near future:

October 6—**Northwestern Ohio Medical Association, 110th Scientific Assembly**, Shawhan Hotel, Tiffin. (Refer to September issue for program, page 865.)

October 13—**Ashland County Medical Society Heart Program**, Miller Memorial Building, Ashland, beginning at 2 p. m. (Refer to September issue for program, page 866.)

October 21—**Eighth Councilor District Meeting**, see announcement in following columns.

October 22—**Conference on Nutritional Aspects of Blood Formation**, Auditorium of the University of Cincinnati College of Medicine, beginning at 9:15 a. m., under sponsorship of the National Vitamin Foundation and the U. C. (Refer to September issue for program, page 865.)

October 22-23—**American Heart Association**, Council for High Blood Pressure Research, Cleveland—see announcement in following columns.

October 25-28—**American Society of Anesthesiologists**, Cincinnati, see details in following columns.

October 27—**Sixth Councilor District, annual fall meeting**, Mayflower Hotel, Akron, registration opens 8 a. m. (Refer to September issue for program, page 866.)

October 27-28 (also November 10-11)—**Frank E. Bunts Institute of the Cleveland Clinic**—see announcement in following columns.

October 29-30 (also November 19-20 and December 17-18)—**Cleveland Area Heart Society** in cooperation with Western Reserve University School of Medicine, courses in resuscitation following cardiac arrest. See program in following columns.

November 10—**Cleveland Chapter of the Arthritis and Rheumatism Foundation** and regional members of American Rheumatism Association, Hotel Carter, Cleveland, beginning at 9 a. m. (Refer to September issue for program, page 866.)

Eighth District Program Scheduled In Newark, October 21

Postgraduate Day of the Eighth Councilor District will be on Thursday, October 21.

While the physicians of the district are meeting at the Moundbuilders Country Club, Newark, from 1:00 P. M. to 4:00 P. M., members of the Woman's Auxiliary of the district will meet at Granville Inn, Granville.

Physicians of the district and their wives will hold a joint dinner session at the Moundbuilders Country Club at 6:30 P. M.

Program for the physicians will consist of the following:

"Medical and Surgical Aspects of Diagnosis and Treatment of Thyroid Diseases," Dr. George J. Hamwi, and Dr. Edwin H. Ellison, Ohio State University College of Medicine.

Motion Picture, "Medical Oddities."

"Treatment of Inoperable and Recurrent Endocrine Tumors of the Breast and Prostate," Dr. Hamwi and Dr. Robert Watman, Ohio State University College of Medicine.

* * *

Heart Association Sponsors Program In Cleveland, October 22-23

Discussions on nerve transmission and muscle metabolism will be featured on the scientific program to be presented at the annual meeting of the Council for High Blood Pressure Research of the American Heart Association in Cleveland on Friday and Saturday, October 22 and 23, at the Hotel Cleveland.

Nationally known discussants compose the program of speakers. Additional information may be obtained from the Cleveland Area Heart Society, 2073 East 9th St., Room 518, Cleveland 15, Ohio.

* * *

American Society of Anesthesiologists To Schedule Program in Cincinnati

The annual meeting of the American Society of Anesthesiologists will be held at the Netherland Plaza Hotel, Cincinnati, Monday, October 25, to Thursday, October 28. Outstanding authorities on anesthesia from all over the United States, Canada and abroad will participate in the program.

Advance registrations for the meeting indicate that more than 2,000 anesthesiologists will attend, Dr. Jay Jacoby, director of anesthesia at

Ohio State University College of Medicine, reported.

The program will consist of both presentation of fundamental research and discussion of practical clinical problems. There will be symposia on circulation, respiration, the control of pain and current research.

Among the presentations will be papers on the use of digitalis in the anesthetized patient, the effect of diabetes on anesthetic and surgical management, advances in artificial respiration and a discussion on pain relief in relation to atomic blast injuries.

All physicians interested in anesthesia are invited to attend this meeting. Its location in Cincinnati presents an excellent opportunity for physicians living in Ohio, since this meeting is held in various parts of the country from year to year.

* * *

Bunts Institute Postgraduate Courses Continue in Cleveland

The Frank E. Bunts Educational Institute, Cleveland Clinic, will hold the last two of its series of fall postgraduate courses in October and November. The first in the series was held September 29 and 30.

The registration fee is $15 for each course, except for interns, residents and members of the Armed Forces in uniform, who will be admitted free, Dr. Fay A. LeFevre, acting director of education, announced.

DISEASES OF THE CHEST

Refer to September issue of *The Journal*, page 864 for course on Diseases of the Chest, October 28-29, sponsored by the Cleveland Society for Diseases of the Chest and the American College of Chest Physicians.

ANNUAL REVIEW COURSE IN GENERAL SURGERY WEDNESDAY, NOVEMBER 10

Morning session opens 9:00 a.m., Dr. R. S. Dinsmore, presiding; "Diseases of the Breast," Drs. Dinsmore, R. K. Gilchrist, R. A. Hays, D. M. Glover and A. H. Robnett.

"Advances in Surgery of the Colon," Drs. R. B. Turnbull, Jr., Gilchrist and Robnett.

"Surgery of the Heart and Lungs," Drs. D. B. Effler, L. K. Groves, H. S. Van Ordstrand and A. Carlton Ernstene; luncheon.

Afternoon session, 2:00 p.m., Dr. George Crile, Jr., presiding. "Diseases of the Pancreas, Drs. Crile, Gilchrist, E. N. Collins and S. O. Hoerr.

"Surgery of the Stomach and Duodenum," Drs. Hoerr, Gilchrist, C. H. Brown and C. R. Hughes.

THURSDAY, NOVEMBER 11

Morning session, 9:00 a.m., Dr. Hoerr, presiding. "Diseases of the Thyroid," Drs. J. B. Hazard, Dinsmore, Grile and E. P. McCullagh.

"Advances in Treatment of Peripheral Vascular Disease," Drs. LeFevre, A. W. Humphries, Robnett, J. G. Root and F. A. Simeone; luncheon.

Afternoon session, 2:00 p.m., Dr. R. B. Turnbull, Jr., presiding; "Development in the Surgical Specialties"; Urology, Dr. C. C. Higgins; Orthopedic Surgery, Dr. J. I. Kendrick; Ophthalmology, Dr. R. J. Kennedy; Otolaryngology, Dr. H. E. Harris; Head and Neck Cancer, Dr. Robin Anderson; Neurosurgery, Dr. W. J. Gardner, and Gynecology, Dr. J. S. Krieger.

* * *

Resuscitation Courses Offered In Cleveland

The Cleveland Area Heart Society is sponsoring a series of postgraduate courses in "Resuscitation Following Cardiac Arrest," in cooperation with Western Reserve University School of Medicine. The classes are practical and informal and are limited to 18 enrollees.

Initial class sessions include explanatory lectures, movies and animal experiments. The second section of the course is concerned with instruction in intratracheal intubation, lectures on predisposing factors, and danger signals leading up to cardiac arrest. Other highlights include lectures and demonstrations at the laboratory table on the physiology of the heart beat and the role of cardiac drugs.

Director of the course is Dr. Claude S. Beck, with Dr. Robert M. Hosler, as associate director. Future courses are scheduled for October 29-30; November 19-20, and December 17-18.

Additional information may be obtained from the Cleveland Area Heart Society, 2073 East 9th St., Room 518, Cleveland 15, Ohio.

St. Francis Hospital, Columbus, To Close Next June 30

St. Francis Hospital, of Columbus, will discontinue operations at its historic location on East State Street and will merge its facilities with an enlarged St. Anthony's Hospital, effective next June 30. The announcement was made by Bishop Michael J. Ready of the Columbus Catholic Diocese.

When the merger becomes effective, the historic building and grounds will revert to Ohio State University under terms of the will of the late Lynne W. Starling. Starling Medical College was housed there at one time.

St. Anthony's Hospital will have a bed capacity of 300 upon completion of the $1,500,000 construction program. It now has a capacity of 180 beds and will add the equal of St. Francis' 120.

Income* for the members of the Ohio Medical Profession from the first day* of sickness or injury...

NOW! Not for only 26 weeks

— Not for only 52 weeks

but even for your entire lifetime

House Confinement not required at any time

Accidental loss of hands, feet or eyesight pays monthly benefits — not just a lump sum

TAX FREE DOLLARS — Disability insurance income is not taxable. For example, $3600 disability insurance income is equivalent to about $5000 regular income

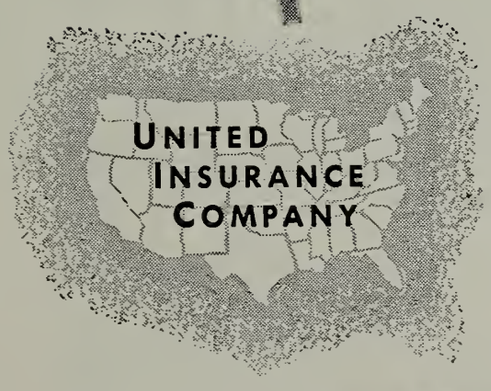
EXTRA BENEFITS — Double monthly benefits while you are hospitalized payable for as long as three months

Cash benefits for accidental death

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Some Practical Suggestions on the Business Side of Medical Practice; Also a Break-Down Study of Why Certain Classes of Patients Don't Pay

HERE are some suggestions regarding the business side of medical practice. They are abstracted from a publication of the Michigan State Medical Society, entitled *Winning Friends for Medicine.*

1. Give recognition and attention to good management of your office and business operations of your practice.

2. Have adequate space and facilities to treat all patients.

3. Employ adequate, qualified personnel and check on their effectiveness and efficiency.

4. Explain medical fees and other medical costs in advance.

5. Never overcharge—never undercut.

6. Reduce or cancel fees when circumstances warrant special consideration.

7. Help save the patient money when possible.

8. Itemize statements.

9. Send bills regularly.

10. Offer long-term plans to patients who have difficulty paying.

11. Promote use of voluntary medical and hospital prepayment plans. Cooperate with patient, insurance companies, and when required, with government agencies in details involved in these relationships.

12. Get adequate information on patient's first visit.

13. Keep public relations principles in mind in following through on collections or when operating through a collection agency.

* * *

The following material is abstracted from a publication prepared for the Committee on Medical Economics of the California Medical Association by the Bureau of Medical Economics of the Alameda County Medical Society.

WHY PATIENTS DON'T PAY

To determine the cause of physician-patient economic difficulties, the Bureau of Medical Economics of the Alameda County Medical Society in cooperation with the California Medical Association conducted a four-month survey covering 1,560 patients whose accounts were delinquent.

Analysis of reasons for non-payment showed the following breakdown:

1. **Adjustable Economic Difficulties—19 per cent.** These people proved to be undergoing financial hardships when contacted by the Bureau. Most involved temporary emergencies.

2. **Poor business methods in the doctor's office —30.23 per cent.** This included no billing; insufficient information to trace "skips"; statements not itemized; no collection follow-up in the doctor's office.

3. **Dissatisfaction with medical services—3.4 per cent.** The Bureau found that one-third of this group had justifiable complaint.

4. **Responsibility for bill disputed—2.04 per cent.** Patients pointed fingers at a divorced husband, a parent, insurance company and others. The Bureau agreed with about a third of them and collected the bill at the proper source.

5. **Excessive fee—2 per cent.**

6. **Patient not informed—21 per cent.** This involved the failure of the doctor to make clear financial arrangements with the patient before treatment or rendering the bill. The patient, in some cases, was not informed of laboratory, x-ray, and other costs.

7. **Negligent; slow pay—9.61 per cent.**

8. **Personality clashes—.86 per cent.** Anger directed at the doctor or his nurse on a personal level.

9. **Deadbeats—10.99 per cent.**

It is re-emphasized that the above figures represent delinquent accounts only, and do not represent the doctors' total practice.

The Bureau noted that when steps were taken to correct the above difficulties collections increased as much as 25 per cent and what is more important, patient satisfaction with the physician and with the economics of medicine increased proportionately.

The authors observe that while the patient's expressed reason for non-payment may not be justified by the facts, it still remains his opinion. As such, it is that man's part of public opinion and must be given full credence when considering public relations.

Regarding the itemization of bills the following comment is found in the article:

"When the first knowledge of his debt to the doctor comes with a bill for $100 or $500—labeled only 'for professional services' and implying demand for immediate payment—the head of the average middle-class family undergoes perhaps four stages of emotion. First is shock. Next is panic. Then comes anger. And this then could, and does, lead to a search for some reason he shouldn't pay the bill. . . ."

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NURSE RECRUITMENT SHOULD HAVE SUPPORT OF PHYSICIANS

The fact that National Nurse Week will be observed October 11-16, offers an opportunity to remind physicians that they can play a leading role in nurse recruitment which is a year-round job.

Nurse recruitment is looking up. However, there are still many openings in nursing schools which are going begging.

Physicians have a grand opportunity to counsel patients or the sons and daughters of patients about their future careers. In doing so, they can get in some good licks for nursing as a career.

Physicians who may wish up to date information on opportunities for nurses, the types of educational programs available, and other important facts so they can give informed guidance, may secure such data from the National League for Nursing, Inc., Committee on Careers, 2 Park Avenue, New York City 16.

Incidentally, folders for waiting room tables are available. Why don't you get some?

DO WHAT LAW SAYS; DON'T PUT DRUGGIST ON THE SPOT

The Columbus Office received a letter recently from a druggist who had run into some difficulty with the State Board of Pharmacy. He was prosecuted and fined for filling a prescription issued by a physician in another city which did not carry the address of the patient. The law provides that the physician writing a prescription should state on the prescription the date of issuance and the name and address of the patient.

The oversight seems like a trivial matter. But, it wasn't in the case of the druggist who had to pay a stiff fine.

Complete cooperation between physicians and druggists on such matters is absolutely essential. The druggist is in a tough spot. If he refuses to fill a prescription which lacks certain required data—which he should do—he many times irritates the customer. If he shuts his eyes at obvious irregularities, then he runs the risk of prosecution.

Each physician should know and understand the law on prescription writing. It goes without saying that he should conform to all legal provisions. He shouldn't expect any druggist to cover up for his errors. No druggist should do so. If the physician and the druggist meet their individual responsibilities, neither will be hurt.

ONLY ONE CHOICE: INSURANCE OR WELFARE

The Congressional Record is fascinating reading to those who may have time to wade through its daily issues. In it you find some mighty interesting and quaint theories advanced.

For example, a recent issue carried the text of a speech on voluntary medical and hospital insurance by a well-known, and supposedly conservative, member of the United States Senate. Here are two paragraphs from the speech:

"As we move forward to meet the different problems, we know that insurance principles are important and must be considered carefully. We should recall, however, that much of what is already being done is being done in spite of insurance principles, and we should regard insurance principles as guides and not as limitations upon our thinking and our planning.

"As we strive to hold down premiums, there should be no resort to cutting and reducing benefits or coverage, for to do so would defeat the very ends we seek."

If the Senator really believes what he said, then he actually places himself in the ranks of those who want to see voluntary medical and hospital insurance plans abandoned in favor of government-controlled plans.

If insurance principles are discarded by the medical and hospital insurance plans, they will become nothing more than welfare programs. Welfare programs must have government subsidy. Government subsidy means government regulations. Net results: The plans become a part of the Welfare State.

WAYS TO REDUCE DAYS IN HOSPITAL SUGGESTED

When the Blue Cross Medical Advisory Committee of the Montgomery County Medical Society was advised by Hospital Care Corporation covering Southwestern Ohio, that its subscribers' average length of stay was one-half day longer than the national average and a full day longer than in other areas of Ohio, the committee issued these recommendations:

To Surgeons—That in uncomplicated surgical cases, the practicability of discharging patients before sutures are removed be considered. Depending on circumstances, sutures would be later removed by the family doctor, or by the surgeon at a home or office call.

To Medical Men—That patients be admitted

only when their condition requires the use or ready availability of hospital facilities.

To Hospitals—That steps be taken to increase the number of hours operating rooms are available, thus eliminating delays between admission of the patient and surgery.

Similar action in all parts of Ohio would undoubtedly benefit physicians, hospitals and Blue Cross, and might be a potential benefit to subscribers as more service inevitably leads to higher premiums.

KREBIOZEN LITERATURE SHOULD BE IGNORED

A number of Ohio physicians have queried the Columbus Office about a 30-page pamphlet received in the mail from the Krebiozen Research Foundation, Chicago. It has been construed as promotion for Krebiozen, as a remedy for cancer. The fact that the pamphlet carries quotes from Dr. Andrew Ivy, a nationally-known medical figure, adds to the confusion.

The Krebiozen episode is an involved one. The *A. M. A. Journal* printed many columns about it a year or so ago. Krebiozen, its supporters, Dr. Ivy, its opponents, and many others were investigated a year ago by a special committee of the Illinois State Legislature. That committee will report its findings to the legislature in 1955.

This much can be said, however: Substantial proof that Krebiozen is scientifically sound and effective is lacking to date.

Therefore, in our opinion, current Krebiozen literature should be ignored.

HOW TO CHOOSE A COLLECTION AGENCY

How to choose a collection agency and how to deal with it are bugaboos to the average physician. Obviously, if he deals with his medical society-sponsored or medical society-approved medical bureau, the physician usually has little to worry about. Most of them have the interest of the physician, and his public relations, at heart. But what about other collection and so-called business agencies for professional men?

A manual issued by the Public Relations Department of the American Medical Association devotes one chapter to collection agencies. Here are the conclusions offered. They should serve as a guide of do's and don'ts for any physician when confronted with this question:

"In brief then, to choose a collection agency wisely, select a local agency with a reputation for reliability and good standing in the community. Avoid out-of-state and mail order agencies. Investigate the methods used. Ask to see the type of first notice and follow-up material. Check up on the ownership and financial responsibility of the agency and its promptness in settling for money collected.

"Do not sign a contract—better agencies seldom use them. Make sure that no legal action or threat of it will be taken without your consent, that the agency will be governed by your instructions to collect only within the scope of good public relations, and that it will report cases deserving your special consideration and accept adjustment, withdrawal, or cancellation of an account when, in your opinion, such action is advisable in the interest of good public relations.

"Once an account has been turned over to an agency, the agency is entitled to a share of any sums paid by the patient either to you or to it. One should be fair and recognize the assistance given in collecting this amount. Be fair with your agency. If these standards cannot be met by any local agency, it is better not to use any collection service at all."

BEWARE OF BAIER, IS OUR SUGGESTION

Understand Ohio physicians have been receiving postal card inquiries from one N. H. Baier, 3837 North Wilton Avenue, Chicago, offering to buy surplus drugs or samples.

Investigation shows that Baier is just an individual who apparently is looking for an easy buck. The Food and Drug Administration in its investigation of him found that it hasn't found anything yet which would warrant prosecution but it did offer the comment that "such a business is definitely full of hazards to the public and should be discouraged." No one seems to know how Baier disposes of the drugs and samples which he undoubtedly gets from some physicians.

In our opinion physicians should have no dealings with Baier or anyone else engaged in an enterprise of this kind.

PRESCRIPTION AGAINST "PHYSICIAN DOLDRUMS"

If you're going to present a medical paper or deliver an address before a medical group or lay gathering, it would be wise for you to avoid giving your audience a bad case of "The Doldrums," according to Dr. Robert P. Barden, Philadelphia radiologist.

Writing in *Radiology*, Dr. Barden offers this prescription as therapy:

Finish the paper before the deadline. If allotted 20 minutes, speak for 17.

Never say all you know, and retire from the podium while your listeners are hoping for more.

Talk in headlines. Explain just enough to make the main thought clear.

Be simple in concept; terse in expressions; logical in progression from one idea to the next.

After rehearsing the presentation alone several times, stop-watch in hand, try it on one of your colleagues—or even your wife.

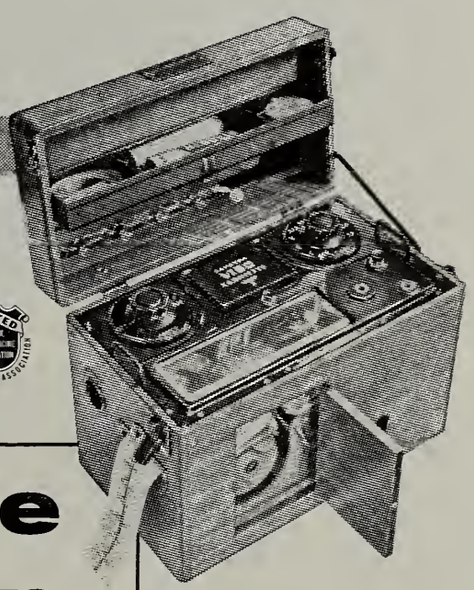
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Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Secretary of Navy has authorized utilization of civilian doctors. For the time being, at least, they will be used only at Navy and Marine Corps industrial activities sites. They may be hired on full-time Civil Service status, or as per diem consultants, or on a fee-for-service basis. Army and Air Force have engaged civilian physicians for some time.

* * *

Dr. Stanhope Bayne-Jones, research director of Army medical department, heads committee on scholarships, grants and research activities of the Robert A. Taft Memorial Foundation. Work is under way to select a memorial to the late Senator.

* * *

Internal Revenue Service recently ruled that a taxpayer's payment of medical and hospital bills for his adult son, not a legal dependent, constituted a gift for income tax purposes . . . since there was "no consideration other than the taxpayer's love and affection."

* * *

Under the Federal Food, Drug, and Cosmetic Act, an applicant for trade clearance of a new drug must tell exactly what it contains. In return he is assured that such information will be kept confidential. A later modification makes it possible for the F. D. A. to release information under certain circumstances.

* * *

Dr. Emma Moss of New Orleans is new president-elect of American Society of Clinical Pathologists, and Dr. Howard A. Rusk, New York, has been chosen president-elect of the American Congress of Physical Medicine and Rehabilitation.

* * *

Federal Trade Commission investigation report of business practices of health and accident underwriters, with particular reference to advertising claims, is due soon.

* * *

Health Advisory Committee to Commission on Intergovernmental Relations has virtually completed its task of surveying Washington's fiscal dealings with states on public health operations.

* * *

Expenditures for hospital and institutional construction in the first eight months of 1954 are estimated by Commerce and Labor Departments at $468 million. Private projects ($212 million) were up 4 per cent over same period in 1953, while public projects were off 8 per cent.

President Eisenhower has indicated that he will press for statutory "adequate" medical care benefits for servicemen's dependents in next session of Congress.

* * *

Evaluation of the results of the National Foundation For Infantile Paralysis vaccine program is in charge of Dr. Thomas Francis, Jr., of the University of Michigan School of Medicine. According to recent statement by a Foundation official, a report on the effectiveness of the vaccine should be ready by April.

* * *

New Commissioner of Social Security is Charles I. Schottland, Los Angeles, former director of California's department of social welfare.

* * *

Dr. Edwin L. Crosby, vice-chairman has taken the reins of the Hoover Commission's medical task force, following the death of Chairman Chauncey McCormick in early September.

Cincinnati Sanitarium Opens New Unit for Ambulatory Therapy

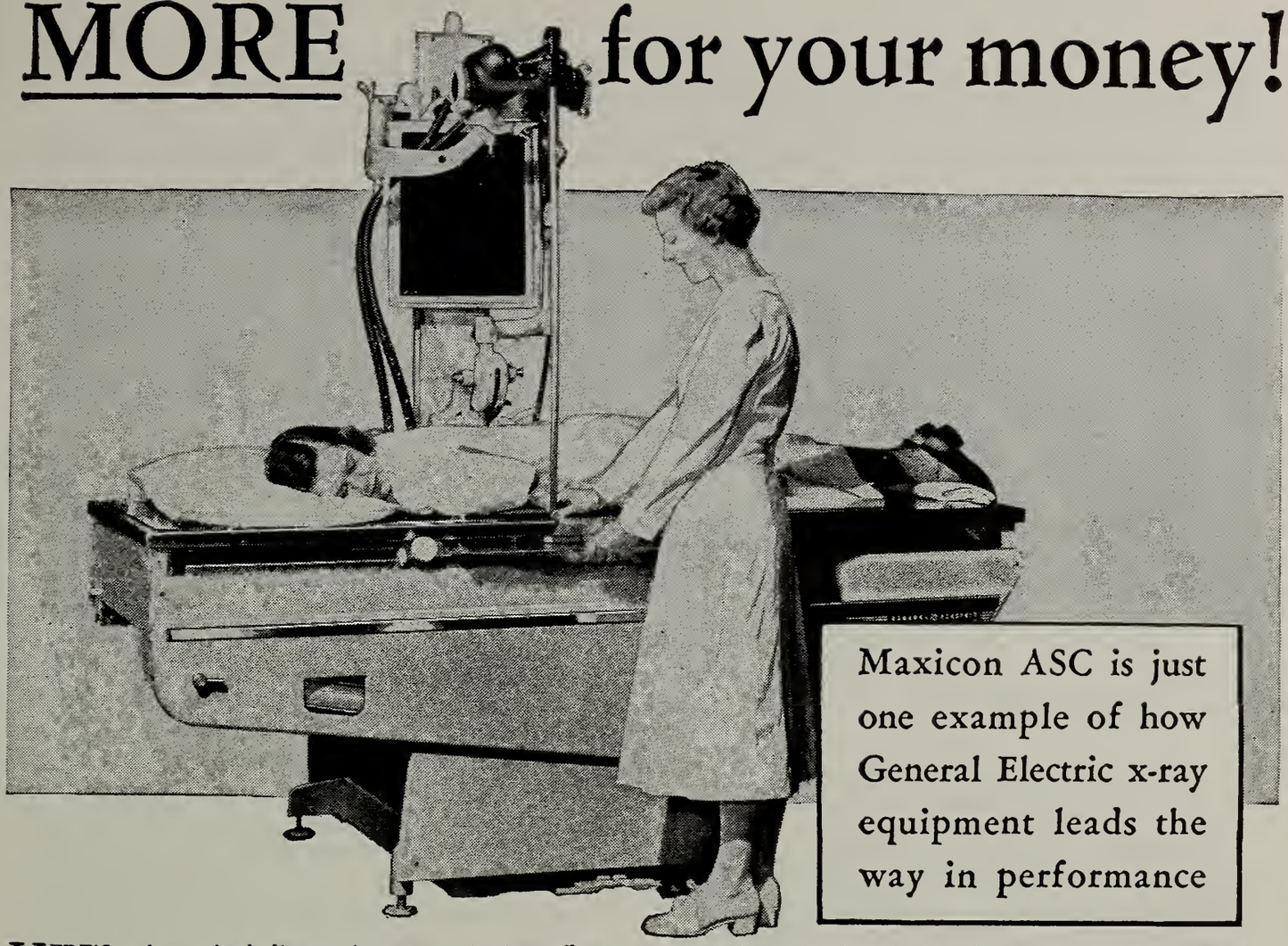
The Cincinnati Sanitarium has announced the opening recently of a new building for the exclusive use of ambulatory out-patient electroshock therapy. The building emphasizes the home atmosphere and arrangements are such as to minimize apprehension and anxiety of patients awaiting treatment.

Known as the Harry Peers Collins Memorial Pavilion, the new building is a memorial to the man who was president of the Cincinnati Sanitarium for 45 years.

The pavilion provides 14 treatment rooms, doctors' consultation room, reception room, equipment room and a shaded patio adjoining the building, making available a picnic area with grill. The lower level contains a new occupational therapy department as well as a large recreation area equipped with billiard tables, television and a snack bar.

Electroshock equipment is in the form of a mobile unit which is rolled to the patient's door where it stays out of sight. Only the needed attachment is brought into the room itself. After treatment, the patient may rest in the recreation center where he can secure light refreshments.

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FEATURE	MAXICON ASC	UNIT X	UNIT Y	UNIT Z
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Variable speed table angulation	YES	NO	NO	NO
Radiation-protective table panels	YES	NO	NO	NO
18-in. focal-spot to table-top distance for fluoroscopy	YES	NO	NO	YES
Counterbalanced tube stand, providing adjustable focal-film distances up to 40 in.	YES	NO	NO	NO
Signal-light centering system for Bucky radiography	YES	NO	NO	NO
Provision for cross-table radiography	YES	NO	NO	NO
12-step line-voltage compensator	YES	NO	NO	NO
Automatic selection of large or small focal spot	YES	YES	NO	NO
45 x 78-in. or less space requirement	YES	NO	NO	NO

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Physician-Attorney Cooperation . . .

Practicing Lawyer Candidly Discusses Practicability of Agreement Reached Between Two Professions in Cincinnati After Year's Trial

AN excellent example of how physicians and attorneys can get together on the local level, discuss their common problems and arrive at definite rules of cooperation is found in such a plan worked out in Cincinnati. The following article describes the events leading up to the cooperative get-togethers, the standards of practice agreed upon and a frank discussion of their practical aspects. The article is the transcript of an address given by C. R. Beirne, a Cincinnati attorney, during the 1954 annual meeting of the Ohio State Bar Association at Youngstown. It is herewith reproduced as it appeared in *The Ohio Bar*, publication of the Ohio State Bar Association.

* * *

COOPERATION BETWEEN PHYSICIANS AND ATTORNEYS—THE CINCINNATI EXPERIMENT

The subject of each of the other members of this panel discussion has to do with certain technical legal aspects of expert testimony. My subject does not relate primarily to expert testimony, but it is concerned with the practical problem of improvement of relations between the lawyer and the most frequently called expert witness—the doctor.

The Cincinnati Experiment had its origin at a baseball game at Crosley Field in Cincinnati, one evening in the summer of 1950 when Dr. Frank H. Mayfield, then president of the Cincinnati Academy of Medicine, and Judge Otis R. Hess, judge of the Common Pleas Court of Hamilton County, took their two sons to the game. Dr. Mayfield had spent some time that day preparing to testify in a personal injury case in which his patient was the plaintiff and Judge Hess had presided in the trial of an action for damages brought jointly against a hospital and a doctor for alleged negligence. A discussion soon developed about the problems which arise when a patient-client requires the services of a doctor and lawyer. Dr. Mayfield said that he was frequently being asked questions by doctors about presenting medical facts to a court and jury; such as, "Why should the doctor be at the mercy of a lawyer when he is on the witness stand?" "Why must the doctor sit around in the court room and waste his time while waiting to be called as a witness?" "Why isn't a written statement of the history, diagnosis, treatment and prognosis made by the doctor sufficient to advise both the court and the jury of the nature of the patient's injury?"

Judge Hess related how the lawyers complained about the lack of cooperation they seemed to receive from doctors whose patients were involved in litigation; that the disinclination to appear in court as a witness had in some instances reached the point where occasionally a doctor even refused to honor a subpoena. Complaint was also being made by lawyers about fees which some doctors charged even for a report pertaining to his own patient where the services of the lawyer were substantially beneficial to the doctor himself, as well as the patient, in making it possible for the doctor to be paid for his services.

It took the frankness of a little boy to break up the conversation and direct the judge's and doctor's attention to the ball game, with the statement, "Why not run your doctor and lawyer business according to rules like baseball?" Unwittingly that boy had hit on something important. On the way home, the judge and the doctor agreed that a better understanding by each professional group of the other's problems and the adoption of a simple set of principles governing their relations with one another would clear up many of the difficulties that they were complaining about and, of more importance, create a feeling of cooperation and mutual consideration each for the other. It was decided to approach the officers of the Academy of Medicine and the Bar Association and to enlist their thinking.

JOINT COMMITTEE

On May 28, 1951, a joint committee of the officers of each association met at the University Club in Cincinnati for an informal dinner meeting. Many subjects were discussed of mutual interest to the two groups; such as, confidential information in the doctor's files, permission to inspect hospital records, problems arising out of litigation where medical testimony is necessary, fees, reports, office conferences before trial, examinations, and other kindred subjects. Before the meeting adjourned, it was agreed by all that a joint meeting of the members of the two associations should be promoted to discuss some of the problems and a committee was appointed to prepare a program.

Two more meetings of the joint committee were held and the subjects to be discussed at the joint meeting of the two associations were agreed upon. Notices were sent out to all the members of the Academy of Medicine, as well as all the members of the Cincinnati Bar Association, announcing the meeting and the subjects for consideration.

On April 22, 1952, the meeting of the two asso-

ciations was held at the Academy of Medicine in the form of a panel discussion. The panel consisted of two doctors who had been selected by the Academy and two lawyers who has been selected by the Bar Association. Judge Hess acted as the moderator. The meeting was opened by a short address by the president of the Academy of Medicine and by the president of the Cincinnati Bar Association.

The discussion was most enlightening. It was apparent that the doctor had a deep-seated conviction that the lawyer had no regard for the doctor's time or understanding of his problems, and the converse was true for the lawyer. The panelists were prepared for most of the subjects which arose for discussion and Judge Hess was an able moderator in steering the discussion along lines where it was felt that something constructive might be accomplished. It was revealing to most of the doctors and lawyers present that their differences were due more to their mutual misunderstanding of the other's problems than anything else. One point was emphasized by Judge Hess and the panelists throughout the discussion; that is, that the development of a cooperative attitude was a personal benefit to the doctor and the lawyer, but of much greater importance, it was a benefit to the public upon whom they are both dependent. The following are some of the subjects which were discussed:

COMPLAINTS ON BOTH SIDES

Doctors' complaints concerning indiscriminate use of the subpoena such as the issuance of a subpoena late in the afternoon or evening for appearance in court on the next morning without prior notice or consultation by the lawyer issuing it.

Failure on the part of the lawyer to take into consideration the doctor's prior engagements at the hospitals and elsewhere with their patients.

Failure on the part of the lawyer to arrange for an appointment with the doctor prior to the trial to discuss the medical questions which might arise.

Failure on the part of the doctor to understand the necessity for personal appearance in court and submitting to cross-examination.

Failure on the part of some doctors to appreciate the function of courts.

It was agreed that most of these complaints were well taken. It was recognized that the doctor's irritation was not lessened when he had endeavored to cooperate by cancelling appointments and rearranging his schedule in order to comply with the subpoena, only to find, when he appeared in court that the case was continued. The discussion continued for two hours and resulted in a resolution the same evening that further meetings between the joint committee of the two groups be held and an effort be made by them to adopt some set of principles which would be a guide for both the doctor and the lawyer on some of the more frequently recurring problems they complained about. It was also agreed that another joint meeting of the two associations be held to consider these principles after they were adopted for recommendation.

Several meetings were held in 1952 and 1953 by the committee. After the matters to be covered by the set of principles had been agreed upon, the lawyer members of the committee were requested to draw up a standard of practice governing lawyers and doctors.

On May 12, 1953, the second joint meeting was held by the two associations at the auditorium of the Academy of Medicine. The form of the meeting was the same as that which had taken place the year before; Judge Hess acting as moderator with two doctors and two lawyers acting as panelists. Each matter contained in the proposed standard of practice was considered separately for discussion. The experience of the previous year was repeated. It was found that after the respective viewpoints had been exchanged, there was some legitimate ground for complaint on both sides and that the proposed standard of practice was acceptable. After certain changes were agreed upon, the following was recommended for adoption by each of the associations:

Standards of Practice Governing Lawyers and Doctors

PREMABLE

Acknowledging that a substantial part of the practice of law and medicine is concerned with the problems of persons who are in need of the combined services of a lawyer, doctor and hospital; and that the public interest and individual problems in these circumstances are best served only as a result of standardized cooperative efforts of all concerned; we, the members of the Cincinnati Bar Association and the Cincinnati Academy of Medicine do adopt and recommend the following declaration of principles as standards of proper conduct for lawyers, doctors and others concerned, subject always to rules of law and standards of legal and medical ethics prescribed for their individual professional conduct.

a. With Respect To Reports To Be Furnished By Doctors

1. Where a report is requested by the patient's attorney, supported by authorization from the patient, and where the report is to be based on information which the doctor can obtain from his own office records or from records at the hospital which were prepared under his supervision, the doctor should furnish said report without charge, regardless of the amount of previous charge made

by the doctor for said treatment; however, where the requested report would require that the doctor check records other than those which are under his own immediate control, a charge should be made in an amount to be agreed upon between the doctor and the patient.

2. Where the report is requested by someone other than the patient, or the patient's attorney, the doctor should insist upon written authorization from the patient before giving the information or the report, and his charge for such report should be in an amount to be agreed upon between him and the person seeking that report.

3. When a report is requested, the lawyer should make clear in his request for a report the specific condition about which he seeks information, and should likewise indicate whether he is asking for a prognosis, or not. The doctor, upon receipt of such request, should answer said request and furnish said report promptly.

b. With Respect To Doctors Being Called To Testify As Witnesses

1. It is recognized that in most instances, it is proper that a conference should be held between the doctor and the lawyer proposing to call him as a witness, at some mutually convenient time before the doctor is to testify.

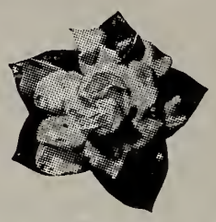
No doctor should be subpoenaed as a witness to testify in any case without prior conference with the lawyer calling him, concerning the matters as to which he is to be interrogated, unless both the doctor and the lawyer agree that such conference is unnecessary.

2. It is recognized that if a consultation fee is to be charged to the patient by the doctor for such conference and, if so, the amount of such fee must in all cases depend upon the circumstances pertaining to each case. Therefore, the amount of fee, if any, to be charged to the patient for such conference shall be a matter of agreement between the doctor, lawyer and patient.

3. It is recognized that the dispatch of the business of the courts cannot depend upon the convenience of litigants, the lawyers or the witnesses, including doctors who are to be called to testify.

Insofar as it is in their power to do so, however, lawyers should make such advance arrangements for the attendance of doctors as witnesses, as will have due regard for the professional demands upon the doctor's time. Such advance arrangements contemplate some reasonable notice to the doctor of the intention to call him as a witness prior to the issuance of the subpoena and calling the doctor by phone after the trial has commenced and advising him of the approximate time when he will be called to testify.

4. When a doctor is called to testify as a witness for his patient, the charge, if any, to be made to such patient, shall be the equivalent of what the charge would be to such patient for



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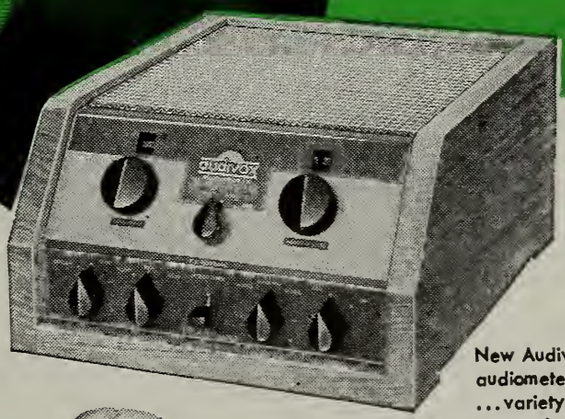
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5. When a doctor is called to testify as an expert witness, he shall be paid such fee as is agreed upon with the lawyer representing the party calling him.

6. No arrangement shall be made whereby the amount of the doctor's charge for his time as a witness shall be determined by the amount of the recovery by the patient in the litigation and nothing herein is intended to alter the rules of law with reference to attendance of witnesses and fees for their attendance, nor the law with reference to privileged communication.

7. When the doctor has not been fully paid by the patient, either for his regular professional services or for his time as a witness or both, the lawyer shall request the permission of the patient to pay the doctor direct for such services out of any recovery of money which the lawyer may receive on behalf of such patient.

APPROVED BY BOTH GROUPS

On January 22, 1954, the foregoing draft of the Standards of Practice was approved by the Executive Committee of the Cincinnati Bar Association and on May 4, 1954, it was also approved by the Council of the Academy of Medicine.

The question naturally arises in your mind: What do you think has been accomplished by the adoption of this standard of practice governing lawyers and doctors?

It was the writer's privilege to serve as one of the lawer-members in the two panel discussions. Personally, I was very much encouraged as a result of these two meetings. I believe the lawyers learned much about the doctors' problems in hearing the medical panelists answer some of the complaints which were made by the lawyers. I believe that the doctors likewise learned much when they heard the lawyers answer some of the complaints that were being made by the doctors. We kept the subjects for discussion limited to those matters which arise most frequently. For the most part, they were very simple matters. Their solution was not difficult once the problem itself was recognized and both viewpoints were given fair consideration. While they were simple, they were nevertheless important. Not only were they aggravating to the doctor and lawyer concerned, but of more importance, in some instances, justice itself was actually being impeded, litigation being delayed and finally, but by no means of any less importance, the public which supports both professions suffered. The discussions served to emphasize the very fundamental fact that the solution of these problems was not only in the self interest of the two groups concerned, but it was mandatory because it was in the public interest that they be so. What excuse can be offered for a lawyer issuing a subpoena late in the afternoon before a trial without even notifying the doctor of the fact that the case was to be tried the next day and without giving the doctor any opportunity to arrange his schedule? Repeated experiences of this kind cause some doctors to take the position that they simply won't come to court. Recently in our county we had a case of a doctor who not only refused to honor a subpoena, but when his secretary accepted a subpoena after a futile effort to make service on the doctor himself, he discharged her. Obviously, his position is untenable and perhaps you feel that drastic action should be taken against him. I agree, but I suspect that the doctor's apparent disrespect for the courts was based upon several experiences with an equally tactless lawyer. If our meetings accomplish nothing more than to cause each group to consider its own shortcomings it was worth the effort.

CONTINUED EFFORT NEEDED

However, I am not so naive as to believe that the mere adoption of the standard will eliminate for all future time the friction which we attempted to eliminate by the rules of conduct incorporated in it. It will be necessary for us to continue our efforts in the future. Joint meetings of the committees of the two associations in the future should be held. It is contemplated that a meeting of the joint committee of the two groups will be held in the fall to discuss further problems not referred to in the existing standards of practice. Perhaps, it would be well if complaints of doctors concerning lawyers could be referred to the doctors' committee for joint discussion of the two committees and complaints of the lawyers concerning doctors could likewise be referred to the lawyers' committee for such joint discussion.

We are encouraged by the results of the Cincinnati experiment. The attendance at both of the meetings was large and the interest created is genuine. It is already evident that a better mutual attitude of cooperation has been created between many of our members. Patience and understanding, as well as education, are necessary. In time, it will pay off. The reward of continued effort is real. It means the elimination of minor irritations for doctors and lawyers. It means that each can serve his patient and client more efficiently and effectively. It means that there will be proper respect for the court and last, but not least, it means better public relations for both professions.

Ashland—Dr. C. E. Fridline was named Ashland County coroner to succeed the late Dr. Herman M. Gunn.

Ironton—Dr. Daniel J. Webster, on his 88th birthday announced that he is retiring from active practice.

In Memoriam . . .

Edward Stanley Anderson, M. D., Columbus; McGill University, Faculty of Medicine, 1924; aged 63; died August 9; member of the Ohio State Medical Association through 1941; member of the American Psychiatric Association. Dr. Anderson had been a staff member of the Lima State Hospital since 1951. Prior to that he was physician to the Ohio Penitentiary.

Paul E. Bethards, M. D., Toledo; Toledo Medical College, 1900; aged 78; died September 2; member of the Ohio State Medical Association and member of the American Medical Association. A life resident of Toledo, Dr. Bethards practiced there for 54 years and had been awarded the 50-Year Pin of the Ohio State Medical Association. Affiliations included membership in the Masonic Lodge. His widow survives.

Allen Weir Freeman, M. D., Baltimore, Md.; Johns Hopkins University School of Medicine, 1905; aged 72; died early this summer; former member of the Ohio State Medical Association. Dr. Freeman was Ohio's first state health commissioner. He left the state in 1921 and subsequently served a 25-year association with Johns Hopkins. His last post was that of consultant with the Maryland State Health Department which he helped to organize.

Herman Melville Gunn, M. D., Ashland; Washington University, St. Louis, 1924; aged 57; died August 23; member of the Ohio State Medical Association and the American Medical Association; former president, vice-president and secretary-treasurer of the Ashland County Medical Society and active as chairman and member of numerous county society committees. Dr. Gunn had been a practicing physician in Ashland since 1928. He also served for a number of years as Ashland County coroner. A veteran of both World Wars, he attained the rank of lieutenant colonel during World War II. He was a member of the American Legion, the Lions Club, several Masonic bodies, The American Association of Railway Surgeons and the Association of Military Surgeons of the United States and was a member of the Committee on Intoxication of the National Safety Council. Surviving are his widow, a daughter, a brother and a sister.

Paul M. Holmes, M. D., Toledo; Columbus Medical College, 1914; aged 63; died August 17; member of the Ohio State Medical Association; the American Medical Association, American College of Chest Physicians, American College of Physicians, American Trudeau Society and diplomate of the American Board of Internal Medicine; former president and vice-president of the Academy of Medicine of Toledo and active on a number of its committees. Dr. Holmes began his medical career with the Columbus State Hospital and later served with the Industrial Hygiene Division of the Ohio Department of Health. He moved to Toledo in 1917 to take charge of industrial hygiene for the Toledo Health Department. Dr. Holmes served with the U. S. Public Health Service during World War I and later returned to Toledo to enter private practice. He was superintendent and chief-of-staff of the Roche Hospital for many years and also medical director for the Oak Ridge Sanatorium in Green Springs. He was a member of the Toledo Club, the Rotary Club and the Unitarian Church. Surviving are his widow and two brothers, one of whom is Dr. J. Howard Holmes, also of Toledo.

Wade E. Jeffers, M. D., Albany; Chicago Physiomedical College, 1895; aged 83; died August 16. Dr. Jeffers, a retired physician, had been a resident of Albany for 20 years. His widow, two sons and four daughters survive.

Joseph P. Keogh, M. D., Youngstown; University of Colorado School of Medicine, 1934; aged 44; died August 9; member of the Ohio State Medical Association; member of the American Medical Association, American College of Surgeons, American College of Chest Physicians and the American Trudeau Society. Dr. Keogh took his internship at Youngstown Hospital Association and returned to Youngstown to practice after doing graduate work in New York. During World War II, he served five years with the Navy, where he attained the rank of commander. He served as head of the Mahoning County Tuberculosis Sanatorium as deputy comptroller of tuberculosis and president of the medical staff. He was a member of the Youngstown Club, the Youngstown Country Club, St. Edward Church, the Chesterton Club. Surviving are his widow, two sons, a daughter and his parents.

Frank W. Koepf, M. D., Columbus; Eclectic Medical College, Cincinnati, 1926; aged 56; died August 14. Dr. Koepf was surgeon for the Pennsylvania Railroad in the Columbus area. He was a member of the Episcopal Church. Survivors include his widow, two daughters and a son.

Claude A. Lingenfelter, M. D., Bucyrus; Homeo Medical College, New York, 1906; aged 70; died August 7; member of the Ohio State Medical Association through 1952; former president, vice-president and treasurer of the Crawford County Medical Society. Dr. Lingenfelter practiced his profession in Bucyrus for 45 years. During World War I, he served as captain with the Medical Corps and later attained the rank of lieutenant colonel with a local medical detachment of the Ohio National Guard. He was a member of the Rotary Club, the American

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Legion, several Masonic bodies, and the Lutheran Church. His widow survives.

Harry T. Martin, M. D., Ashland; Eclectic Medical College, Cincinnati, 1916; aged 65; died July 23; member of the Ohio State Medical Association; active on a number of committees of the Ashland County Medical Society. A practicing physician for 38 years, Dr. Martin moved to Ashland from Lafayette (Allen County) in 1937. He was a member of the Christian Church and the Masonic Lodge. Survivors include his widow, a son, a daughter, a sister and a brother, Dr. J. W. Martin, Uniontown, Pa.

Ilya Mark Scheinker, M. D., New York City; University of Vienna, Austria, 1931; aged 52; died August 25; former member of the Ohio State Medical Association; member of the American Association of Neuropathologists and the Association for Research in Nervous and Mental Diseases; diplomate of the American Board of Psychiatry and Neurology. Dr. Scheinker resided in Cincinnati from 1941 to 1948, where he was assistant professor in neuropathology at the University of Cincinnati College of Medicine. He is survived by several brothers and sisters.

Civil Service Has Several Openings for Physicians

The U. S. Civil Service Commission has announced that there are several openings for positions as Medical Officer and Medical Officer (Specialist) in various Federal agencies in Washington, D. C., and throughout the United States, and Medical Officer positions in the Panama Canal Zone.

Field positions are available in the various Federal agencies, located in Washington, D. C.; Arlington and Fairfax Counties, Va.; Alexandria, Va.; Prince Georges and Montgomery Counties, Md.; and positions in the Children's Bureau and the United States Health Service, including the National Institutes of Health, of the Department of Health, Education and Welfare, located throughout the United States.

Physicians interested in the Panama Canal Zone assignments should write: Board of U. S. Civil Service Examiners, Balboa Heights, Canal Zone.

Those interested in other assignments should write: The U. S. Civil Service Commission, Washington 25, D. C.

Study Shows Toll From Rheumatic Fever Is on Decline

Marked progress is being made in reducing the toll from rheumatic fever among American children, statisticians of the Metropolitan Life Insurance Company report on the basis of declining mortality from the disease over the past decade.

Accelerated improvement during the past 10 years is attributed in part to general betterment in living conditions, but more particularly to the greater control over streptococcal infections obtained through the use of sulfa drugs, penicillin, and other antibiotics. The new therapy, it is noted, has been effective in preventing both initial and recurrent attacks of rheumatic fever.

The favorable outlook for children who have rheumatic fever is brought out by a follow-up study of nearly 3,000 children who received nursing care during an acute attack of rheumatic fever during the 1936-1938 period. This study showed that the great majority of the children were still living at the end of 15 years. A survivorship rate of 94 per cent was recorded among girls under age 10 at the time of attack for whom no evident heart disease was reported at first observation. The death rate among these children has declined with increasing time elapsed since attack.

Attorney General Opinions

The following opinions of interest to the medical profession were rendered recently by Attorney General C. William O'Neill:

Opinion No. 4028—The local registrar of vital statistics in a primary registration district which is also a city health district, which health district is governed under the provisions of a city charter, is entitled to retain the fees collected by him pursuant to Section 3705.13, Revised Code, even though he is appointed by the mayor of the city and even though he is at the same time an employee of the city in another capacity.

Opinion No. 4030—A board of county commissioners has authority under the provisions of Section 339.01, Revised Code, to "enlarge, improve, and rebuild" an existing county hospital, and in exercising such power such board should act directly rather than by making funds for such purpose available to the board of trustees of such hospital.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D., MIDDLETOWN)

CLERMONT

The Clermont County Medical Society met on September 15 at the D-X Ranch, Bethel, with Dr. O. C. Davison as host. Guest speaker was Dr. Homer H. Kohler, Cincinnati, who spoke on "Urinary Tract Infections."

HAMILTON

The Academy of Medicine of Cincinnati has announced an excellent program schedule which covers meetings for the entire season ending next May.

The opening meeting of the season and annual meeting of the Academy was held on September 21. Guest speaker was Dr. Leonard A. Scheele, Surgeon General of the United States Public Health Service, Washington, D. C. His subject was "Plans and Programs of the Department of Health, Welfare and Education in the Field of Health."

The tentative program of future meetings is as follows:

October 5—A symposium on "Complications of Pregnancy" consisting of the following panel: Dr. Albert A. Brust, associate professor of medicine, Emory University School of Medicine, Atlanta, Ga., "Medical Complications."

Dr. Robert A. Garrett, chairman, Department of Genito-Urinary Surgery, Indiana University Medical Center, Indianapolis, "Urological Complications."

Dr. Richard D. Bryant, associate professor of obstetrics, University of Cincinnati College of Medicine, moderator.

October 19—"Supervoltage X-Ray and the Cobalt Bomb in the Treatment of Cancer," (joint meeting with the Cancer Council), Dr. Milton Friedman, associate professor of clinical radiology, New York University.

November 9—"Management of Diabetes Mellitus by the General Practitioner," (joint meeting with the Diabetes Council), Dr. Garfield G. Duncan, clinical professor of medicine, Jefferson Medical College.

November 23—"Clinico-Pathologic Analysis of the Nephrotic Syndrome," Dr. Arthur C. Allen, associate professor of pathology, Cornell, and associate pathologist of Memorial Center for Cancer and Allied Diseases, New York.

December 7—"Significance of Abnormal Cardiac Sounds and Murmurs," (joint meeting with the Heart Council), Dr. Howard B. Sprague, clinical associate in medicine, Harvard.

January 18—A symposium on "The Adrenal Cortical Hormones," with a panel consisting of the following: Dr. Albert Segaloff, director of endocrine research, Alton Ochsner Medical Foundation, New Orleans, "The Effects of an Excess of Cortical Hormones"; Dr. Charles W. Lloyd, associate professor of obstetrics (Division of Endocrinology) State University of New York, "The Effects of Insufficient Cortical Hormones"; Dr. William D. Lotspeich, professor and director, Department of Physiology, University of Cincinnati, moderator.

February 1—"X-Ray Lesions of the Gastrointestinal Tract," Dr. Edward B. D. Neuhauser, radiologist-in-chief, Children's Medical Center, Boston.

February 15—"Clinico-Pathological Aspects of Parathyroid Disease," Dr. Benjamin Castleman, clinical professor of pathology, Harvard Medical School, and chief of the Department of Pathology, Massachusetts General Hospital, Boston.

March 1—"Use and Abuse of Dietary Measures in the Treatment of Gastrointestinal Disorders," (Roger Morris Lecture), Dr. Franz J. Ingelfinger, associate professor of medicine, Boston University School of Medicine.

March 15—A symposium on "Dizziness and Related Disorders in General Practice," Dr. Albert C. Furstenberg, dean of the Medical School and professor of otolaryngology, University of Michigan, "A Practical Consideration of Vertigo,"; Dr. Stewart Wolf, professor and head of Department of Medicine, University of Oklahoma, and supervisor of clinical activities, Oklahoma Medical Research Foundation, "The Role of Emotional Disturbance"; Dr. Charles D. Aring, professor and director of Department of Neurology, University of Cincinnati, moderator.

April 5—A symposium on "Industrial Problems in Medicine," with the following panel: Dr. Rutherford T. Johnstone, consultant in industrial medicine and clinical professor of medicine, University of California, "The Diagnostic Approach to the Occupational Diseases"; Dr. W. P. Shepard, second vice-president, health and welfare, Metropolitan Life Insurance Company, and chairman of the Council on Industrial Health, American Medical Association, "Industrial Health —A Challenge to Medicine"; Dr. Robert A. Kehoe, professor and director, Department c Preventive Medicine and Health, University of Cincinnati, moderator.

May 3—"Surgical Diseases of the Esophagus," Dr. Richard H. Sweet, associate clinical professor of surgery, Harvard.

May 17—"The Doctor-Patient Relationship:

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Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

DARKE

The Darke County Medical Society met at the James Hotel, Greenville, for dinner and a meeting on September 21. Speaker of the evening was Chesta Fulmer whose subject was "Why Women Leave Home."

GREENE

Dr. William P. Montanus, Springfield, spoke on the subject, "The Surgical Treatment of Diverticulitis in Its Complicated Stage," at the June 10 meeting of the Greene County Medical Society in Xenia. Dr. Robert F. Swanson was voted into membership at this meeting.

At the first fall meeting, September 9, Dr. Robert C. Austin, Dayton, spoke on "Physiological Concept in the Management of Thyroid Disease."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The Inter-Hospital Postgraduate Lecture Series is being presented by the Medical Advancement Trust of Maumee Valley Hospital, Toledo, on Thursday and Friday, October 14 and 15.

Guest speaker will be Dr. William A. Sodeman, chairman of the Department of Medicine, University of Missouri Medical College. Three lectures are scheduled each of the two days at 12 o'clock noon, 4:30 p. m. and 8 p. m. All are at the Academy of Medicine Building. The respective lectures are as follows:

October 14—"A Reevaluation of the Problem of Acute Pericarditis"; "The Problem of Refractory Heart Failure," and "Atherosclerosis —Pros and Cons in Cause and Treatment."

October 15—"Hepatitis—Its Recognition and Treatment"; "Chronic Diarrhea," and "Medicine in India" (a mixture of travel pictures plus medical oddities in India).

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

SUMMIT

"The Nature and Treatment of Hypertension," was the subject discussed at the September 7 meeting of the Summit County Medical Society at the City Hospital of Akron Nurses' Home. Guest speaker was Dr. Irvine H. Page, director of research at the Cleveland Clinic.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

Dr. Elmer R. Maurer, Cincinnati, spoke on the subject, "Problem Lesions in the Chest, Their Diagnosis and Treatment," at the September 13 meeting of the Scioto County Medical Society in Portsmouth.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

KNOX

The Knox County Medical Society in July made public a resolution by which members of the Society went on record as favoring a joint health district combining the Mt. Vernon and Knox County health departments.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The regular monthly meeting of the Lorain County Medical Society was held September 14 at the Spring Valley Country Club, Elyria, beginning with dinner. A business meeting followed the dinner.

Speaker of the evening was Dr. David W. Heusinkveld, Cincinnati, President-Elect of the Ohio State Medical Association, who spoke on "The Role of Art in the Practice of Medicine."

Trumbull Memorial Hospital Opens New Wing

The new five-story addition at the Trumbull Memorial Hospital, Warren, was formally opened in August. The 182-bed addition was constructed at a cost of $1,851,000.

Total cost of the hospital expansion program will be $2,800,000, which includes a new laundry, power house equipment, renovation of the existing center section and remodeling of the east and west wings. When completed the hospital will have 326 beds and 76 bassinets.

A. M. A. Sponsors Meeting on Medical Care of Mine Workers

Health of the mine worker will be discussed at the third conference on "Medical Care in the Bituminous Coal Mine Areas" to be held October 23 and 24 in Huntington, W. Va. Sponsored by the A. M. A.'s Council on Medical Service, this year's conference will stress the "Practitioner's Point of View." Representatives from Kentucky, Tennessee, Pennsylvania, Virginia and West Virginia as well as representatives of the United Mine Workers of America medical department will attend.

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Personal communication (Apr. 12, 1950)

1951 Of 119 patients treated with Azulfidine prior to 1944, 90 patients (75%) were symptom-free or considerably improved when re-examined in 1949.

Svartz, N.: Acta. Med. Scandinav. 141:172, 1951.

1952 In a series of 52 patients with chronic ulcerative colitis 30, or 58%, showed significant improvement after treatment with Azulfidine.

Morrison, L. M.: Gastroenterology 21:133, 1952.

1953 *Morrison says:* "Azopyrine [Azulfidine] . . . has been effective in controlling the disease in approximately two-thirds of patients who had previously failed to respond to standard colitis therapy currently in use."

Morrison, L. M.: Rev. Gastroenterology 20:744 (Oct.) 1953.

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Past President—Mrs. N. M. Reiff, 404 Rawlings St., Washington Court House, Ohio

HURON

The Woman's Auxiliary to the Huron County Medical Society met at the home of Mrs. A. N Kimmel, in Norwalk on September 10. A dessert luncheon was enjoyed by all and was followed by the first business session of the New Year. The minutes of the previous meeting were read and a financial report by the treasurer, Mrs. Charles Edel, showed a substantial amount in the Savings account. Auxiliary officers are looking for an eligible young lady, who is interested in a nursing course at an Accredited School of Nursing.

Mrs. T. H. Smith, as a delegate, gave a fine report, covering the National Convention, which was held in San Francisco. She also delighted all with 3 D shots, in color of the many scenic spots, along the entire route of her trip. The next meeting is scheduled for October 8, with Mrs. R. C. Gill of Norwalk as hostess.

LUCAS

The Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County held its annual membership meeting at the Toledo Country Club in May. The retiring president, Mrs. Boni Petcoff, gave her report, which was followed by the election and installation of officers. The necrology was conducted by Mrs. E. Benjamin Gillette. Mrs. E. L. Burns will serve as the new president; Mrs. C. J. A. Paule, president-elect; Mrs. C. R. Forrester, vice-president; Mrs. G. H. Lemon, recording secretary; Mrs. J. M. Hertzberg, corresponding secretary; Mrs. A. R. Klopfenstein, treasurer; Mrs. B. H. Shulack, assistant treasurer:

Mrs. Harry C. Conn was in charge of the entertainment, a very amusing playlet directed by Mrs. John Richards. Members of the Auxiliary were in the cast and proved themselves excellent entertainers. They have been asked to display their talents before several civic organizations and also for the medical Academy.

Plans for the fall season of the Auxiliary were made at committee meetings during the summer months. Mrs. R. P. Whitehead, Jr., chairman of the year book, was hostess to her committee members in her home on Mt. Vernon Rd. Mrs. W. LeRoy Bryant, program chairman, entertained at a luncheon in her home on Pemberton Drive. Members of the fund-raising group met with Mrs. O. H. Stone, chairman, in the Academy of Medicine Bldg. Mrs. James R. McAuley, chairman of the members sponsoring *Today's Health*, held at luncheon in her home at Perrysburg. Mrs. John F. Buck, general chairman of the Auxiliary's study groups, entertained at a luncheon in the Hillcrest Hotel.

Thirty members of the Auxiliary were appointed to act as hostesses at the County Fair health exhibit in August. The exhibit featured displays by local and national health agencies and also presented the latest information available from the American Medical Association. Mrs. Arthur W. Hemphill was chairman of the exhibit, and Mrs. Herbert C. Weller, co-chairman.

Define Eligibility of U. S. P. H. S. Officers in A. M. A.

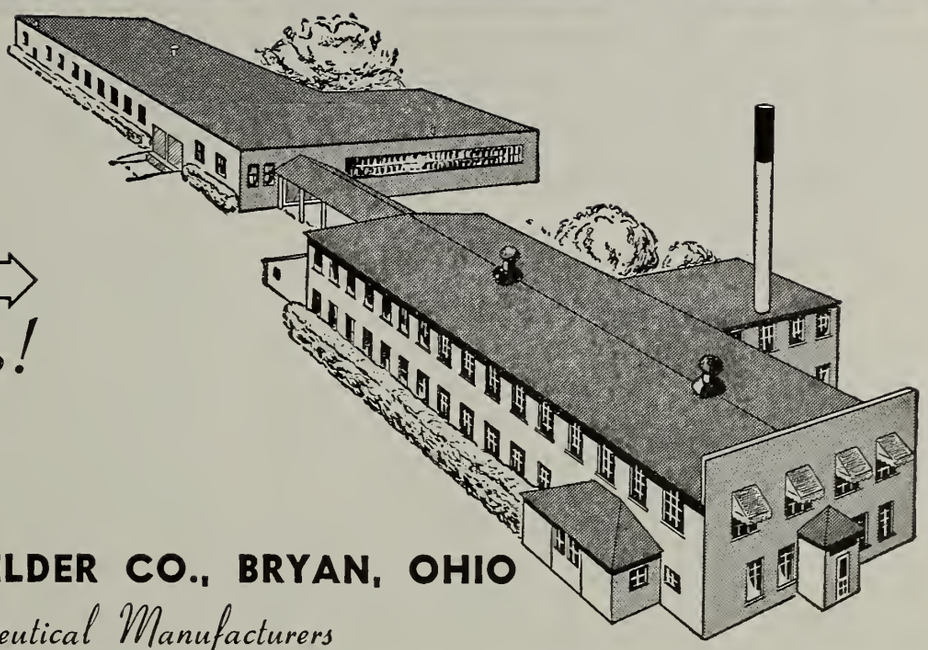
At the A. M. A. San Francisco meeting a resolution was introduced, requesting that reserve officers of the United States Public Health Service who are on active duty be given service membership in the A. M. A. The resolution was referred to the Board of Trustees, which has since ruled that:

"Reserve medical officers of the United States Public Health Service on active duty are to be given the same consideration as that extended to reserve medical officers on active duty with the military forces. In other words, those officers will be exempted from payment of dues for the period beginning January 1 or July 1 following the date of the member's entrance into the service."

All such officers who hold a type of membership in the constituent medical association that permits them to vote and hold office will be eligible to hold active membership in the A. M. A. and be excused from the payment of dues. It will be necessary, therefore, for their names to be forwarded through their constituent medical society to the A. M. A. with the request for exemption from the payment of A. M. A. dues. During the period for which they are exempted, they are not entitled to receive *The Journal of the American Medical Association* as a benefit of membership, but may subscribe to it, or to other A. M. A. publications. Such officers will be given active membership in the A. M. A. and not service membership.

Service members are regular, full-time medical officers in the Army, Navy, Air Force, U. S. Public Health Service, Veterans Administration, and Indian Service, and are not required to hold membership in a component and constituent association.

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You and Your A. M. A. . . .

Some High Lights and Side Lights on What the American Medical Association Is Doing in Its Extensive and Far-Reaching Program

NAME CHANGE FOR A. M. A. COUNCIL

"Only the name has been changed . . ." At its last meeting, A. M. A.'s Board of Trustees approved a change in name only for the Council on National Emergency Medical Service which from now on will be known as the Council on National Defense. As formerly, the Council assists with national and state disaster relief plans and coordinates the work of state emergency medical service committees.

MONIES FOR MEDICAL SCHOOLS

The first 1954 distribution of unrestricted funds to the nation's 80 medical schools was made in July by the National Fund for Medical Education. These 1954 grants totalled $2,176,904.71, including $1,101,000 from the medical profession through the American Medical Education Foundation.

Each of the 74 four-year medical schools received $15,000 plus $25 per undergraduate medical student enrolled in the school. Each of the six two-year schools received $7,500 plus $25 per student. Added to these grants were gifts of individual doctors to designated schools.

Since 1951, nearly seven million dollars has been awarded to the country's medical schools —half of this total contributed by the medical profession. Fund grants, which are unrestricted, are used by the schools primarily to fill teaching vacancies, to create new faculty posts and to initiate courses in areas of recent scientific advances.

LAURELS FOR A. M. A. FILM

Two honors recently were heaped on the popular documentary film, "A Citizen Participates," on which the A. M. A. holds television rights. The film received top rating as an educational motion picture at the Cleveland Film Festival and was chosen by *Scholastic Teacher* for a national film award as a 16 mm. information film.

A. M. A. SETS UP LAW DEPARTMENT

Something new has been added . . . to A. M. A.'s long list of councils, committees and departments. Known as the Law Department, the newly established department will handle all requests for legal opinions and advice by the various headquarters staff offices. Effective August 1, the Bureau of Legal Medicine and Legislation and the headquarters staffing of the Committee on Legislation was transferred to the new department.

Director is C. Joseph Stetler, who has been secretary of the Council on National Emergency Medicine Service since 1951. Mr. J. W. Holloway, Jr., who has headed the Bureau of Legal Medicine for many years, serves as consultant to the new office.

Bernard D. Hirsh, Chicago attorney who has served in several responsible federal positions, has joined the staff and brings to five the number of attorneys employed full time including the director.

NEW FILM CATALOG READY

The revised catalog of medical and health films now available from the A. M. A.'s Committee on Medical Motion Pictures may be obtained on request from the Committee. This booklet gives brief descriptions of more than 100 films.

NEW TV FILM EXPOSES QUACK MEDICAL MAN

Begin making plans now for your local television station to show A. M. A.'s newest film—



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"A Life to Save." Produced especially for use on local stations by state and county medical societies, this 27-minute film will be available for bookings October 1 through A. M. A.'s TV Film Library.

This new film—part of which was filmed at A. M. A. Headquarters—is the story of how a woman's life is saved by her family doctor after a quack healer is exposed.

DOCTOR STORY ON ABC-TV

Pathos, humour and hope—these are the emotions reflected in a 24-hour period in the life of Dr. Ben Collins as dramatized in "The Doctor" on the "Cavalcade of America" program Tuesday, November 9, over the ABC television network. The leading role will be played by Hollywood actor, Dean Jagger.

Of special interest to all physicians is the fact that this well-written script presents a true picture of the role of the typical general practitioner in safeguarding health in communities across the nation.

Doctors are urged to watch for this outstanding television program and to call it to the attention of their patients. Check local newspapers for date and time of the "Cavalcade of America" show in your area.

A. M. E. F. NEARS ONE MILLION MARK

Several large contributions from state medical associations have boosted the American Medical Education Foundation nearer to its goal of two million dollars in 1954. The California Medical Association recently contributed $100,000. Another large contribution came from the Arizona Medical Association in the amount of $7,230, which represents a $10 per member dues increase voted for A. M. E. F. by the association. Both Arizona and Utah have followed Illinois physicians by voting a dues increase as a method of increasing contributions from their states.

Since January 1, 1954, the Foundation has received a total of $968,000 and expects to reach the one million mark in September.

7TH PR CONFERENCE TO BE HELD IN MIAMI

Public relations tips "for doctors only" will be presented at A. M. A.'s seventh National Medical Public Relations Conference to be held in Miami Sunday, November 28, the day preceding the opening of the Clinical Session.

A. M. A. PRODUCES NEW RADIO SERIES—"35"

How to lead a healthy, happy life when you reach the half-way mark—35 years of age—is the theme of a new radio transcription series prepared by A. M. A.'s Bureau of Health Education.

Each program topic is dramatized by a cast of outstanding actors and then discussed by a physician. The following subjects are included—heart disease, cancer, arthritis, high blood pressure, mental health, surgical advances, rehabilitation, preparation for old age, endocrinology, diseases of the blood, general therapeutics, nutrition, and diabetes.

The "Thirty-five—Mid-point of Life!" series is available for distribution to state and county medical societies for airing over local radio stations.

Jackson—A resolution by the Jackson County Board of Health expressed appreciation for the excellent services of Dr. Brinton J. Allison, health commissioner since the department was organized 22 years ago.

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Conference on Rehabilitation To Be Held in Cincinnati

Physicians of southwest counties of Ohio as well as lay workers in the field of rehabilitation will be interested in a division meeting of the Ohio Welfare Conference in Cincinnati on November 10 and 11 with a program on rehabilitation.

NOVEMBER 10

9:30 a. m. to 12 noon

"The Community Rehabilitation Program—What Is It?" A panel of the following persons and topics:

Professor Kenneth Hamilton, Graduate School of Social Administration, Ohio State University and associate director, Rehabilitation Center, O. S. U., moderator and discussant on the subject, "Philosophy of Rehabilitation, the Team Concept, Case-Finding and Referral."

Dr. Robert J. Murphy, medical director, Rehabilitation Center, O. S. U., "Medical and Related Services—Medical Evaluation and Treatment, Hospitalization, Physical Restoration, Occupational and Physical Therapy, etc."

Mrs. Jane Devereaux, the Detroit League for the Handicapped, "Psychosocial Services—Psychosocial Evaluation, Casework Services, Psychological Testing."

William Lakin, Dayton Goodwill Industries, "Pre-Vocational Services, Vocational Testing, Counseling and Training."

Paul Messmer, Ohio State Bureau of Unemployment Compensation, Columbus, "Employment Services—Job Referral, Placement and Follow-Up, Methods Used in Opening Up New Employment Opportunities for Handicapped Persons."

NOVEMBER 11

9:30 a. m. to 12 noon

The moderator will be Dr. Abraham Jacobs, director of vocational rehabilitation, Longview State Hospital, Cincinnati. The cases of three clients will be presented by the staff members of various agencies which have served the clients. The cases will be discussed and questions from the floor will be answered by a panel consisting of the following persons:

Mrs. Thelma P. Allardyce, chief casework supervisor, Public Assistance Division, Hamilton County Welfare Department.

Dr. Louis J. Finkelmeier, medical consultant, Goodwill Industries Rehabilitation Center, Cincinnati.

Homer Hallett, counselor, Ohio Department of Public Welfare, Rehabilitation Services for the Blind, Cincinnati.

Miss Evelyn Lempereau, district supervisor, Ohio Bureau of Vocational Rehabilitation, Cincinnati.

Greenville—Dr. Maurice M. Kane was named president of the newly organized Darke County Heart Council, and Dr. Peter H. Mulder, of Arcanum, vice-president.

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Report Shows Extensive Activities Of United Mine Workers Fund

Reserves of the United Mine Workers of America Welfare and Retirement Fund rose by $1,540,312 during the fiscal year ended June 30, 1954, the Fund's annual report, recently released, showed. Receipts for the year amounted to $134,847,779; expenditures totaled $133,307,466. The unexpended balance in the Trust Fund on June 30 was $93,565,044.

Benefits paid to 276,763 miners and members of their families during the year amounted to $129,296,261.

The report also totaled up the amount of money taken in since May, 1946, when the welfare program started.

During that eight-year period, total revenues were $753,196,122. On the expenditure side, pensions accounted for $260,027,905. Hospital and medical care accounted for another $203,479,715. Cash aid of $105,006,474 was paid to disabled miners, while another $72,781,972 in cash benefits went to widows, orphans and survivors of coal diggers.

During the last fiscal year alone, pensions of $64,092,309 were paid. As of June 30, 1954, there were 54,937 aged, retired miners receiving the pension of $100 a month.

Widows, orphans, and other dependents of coal miners received a total of $7,524,684 in cash benefits during the year. Funeral expense and survivors benefits of $3,069,277 were paid to 3,768 families of deceased miners. Additional aid of $4,395,373 in cash was paid to assist 24,150 widows and orphans. This latter type of temporary benefit was discontinued by the Trustees as of April 1, 1954, as was the cash assistance to disabled miners.

Disaster benefits of $60,033 were paid to 521 widows and orphans of 245 miners killed or gravely injured on the job.

The hospital and medical care provided by the Fund totaled $52,209,912 in the twelve months ended June 30, the report showed. This meant 2,058,130 days of hospitalization for 115,274 Fund patients in 1,739 hospitals located in 45 states, the District of Columbia and Alaska.

The 34-page report details also the Fund's work in the field of physical rehabilitation of miners and their families and progress in the construction of ten hospitals for Fund beneficiaries in Kentucky, West Virginia, and Virginia.

Dayton—Dr. A. V. Black, Centerville (Montgomery County), discussed "Use of Electricity in Modern Medicine," before a meeting of the Dayton Chapter, American Institute of Electrical Engineers.

Cook County
Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

SURGERY—Surgical Technic, two weeks, Oct. 11, Nov. 8. Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, Oct. 11. Surgical Anatomy & Clinical Surgery, two weeks, Oct. 25. Surgery of Colon & Rectum, one week, Oct. 25. Breast & Thyroid Surgery, one week, Oct. 25. Thoracic Surgery, one week, Oct. 11. Esophageal Surgery, one week, Oct. 4. General Surgery, one week or two weeks, Oct. 4. Gallbladder Surgery, ten hours, Oct. 25. Fractures & Traumatic Surgery, two weeks, Oct. 25.

GYNECOLOGY—Office & Operative Gynecology, two weeks, Oct. 18. Vaginal Approach to Pelvic Surgery, one week, Nov. 1.

OBSTETRICS—General & Surgical Obstetrics, two weeks, Nov. 1.

MEDICINE—Electrocardiography & Heart Disease, two weeks, Oct. 11. Gastroenterology, two weeks, Oct. 25. Gastroscopy, two weeks, Nov. 8.

RADIOLOGY—Diagnostic Course, two weeks, Oct. 4. Clinical Uses of Radio Isotopes, two weeks, Oct. 4.

PEDIATRICS—Clinical Course, two weeks, by appointment. Congenital & Rheumatic Heart Disease in Infants & Children, one week, Oct. 11 and Oct. 18. Two weeks, Oct. 11.

DERMATOLOGY — Intensive Course, two weeks, Oct. 18.

CYSTOSCOPY—Ten-Day Practical Course, every two weeks.

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COMING MEETINGS

Ohio State Medical Association, 1955 Annual Meeting, week of April 18, 1955, Cincinnati.

American Medical Association, 1955 Annual Meeting, June 6-10, 1955, Atlantic City, N. J.

American Medical Association, 1954 Clinical Meeting, Nov. 29- Dec. 2, 1954,, Miami, Fla.

Second Councilor District Meeting, October 1,, Dayton.

American Academy of Pediatrics, Oct. 4-7, Chicago.

Central Association of Obstetricians and Gynecologists, Oct. 6-9, St. Louis, Mo.

Northwestern Ohio Medical Association, Oct. 8, Tiffin.

Academy of Psychosomatic Medicine, Oct. 8-9, New York City.

Ashland County Medical Society Heart Program, Oct. 13, Ashland.

Eighth Councilor District, Postgraduate Day, Newark, October 21.

Symposium on the Nutritional Aspects of Blood Formation, Oct. 22, Cincinnati.

American Heart Association, Council for High Blood Pressure Research, Cleveland, Oct. 22-23.

American Society of Anesthesiologists, Oct. 25-28, Cincinnati.

Annual Convention of the National Gastroenterological Association and of the American College of Gastroenterology, Oct. 25-27, Washington, D. C.

Sixth Councilor District, Oct. 27, Akron.

The Frank E. Bunts Educational Institute, Cleveland Clinic, Postgraduate Course, Oct. 27-28, Cleveland.

Frank E. Bunts Educational Institute, Cleveland Clinic, Postgraduate Course, Nov. 10-11.

Election Day, November 2.

Annual Clinical Congress of American College of Surgeons, Nov. 15-19, Atlantic City, N. J.

Cleveland Area Heart Society, Course in Resuscitation, October 29-30, November 19-20, December 17-18.

American College of Surgeons Section Meeting, Cleveland, February 21-24.

Cambridge—Dr. Arthur T. Hopwood, superintendent of Cambridge State Hospital, received an Award of Merit from the Special Class Teachers Association of Massachusetts. As president of the American Association on Mental Deficiency, Dr. Hopwood reviewed and recommended passage of a bill in the Massachusetts Legislature for creation of a department of education, which included a special provision for the mentally retarded.

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FOR SALE: Bargain, Picker fluoroscope, practically unused. Can be seen at Montgomery County Tuberculosis Clinic, 213 North Ludlow St., Dayton 2, Ohio. Contact E. F. Conlogue, Dayton. Telephone RA 1135.

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Medical Civil Defense Conference To Be Held in Chicago

Medical civil defense leaders will hold their fifth national conference in Chicago at the Bismarck Hotel, Saturday and Sunday, October 30-31.

At its last conference in Cincinnati, the Target Areas Medical Civil Defense Organization changed its title officially to The County Medical Societies Civil Defense Organization.

Physicians who have access to a registration blank should send it with their registration fee as indicated on the blank. Interested physicians who do not have a blank should contact Dr. Harry R. Mendelsohn, 4534 Whetsel Ave., Cincinnati 27, Ohio (Phone BR 1615). Registration fee is $5 which is charged to defray expenses of the meeting.

Those who plan to attend should reserve their own rooms by writing to The Bismarck Hotel, 171 West Randolph St., Chicago.

Cleveland—Upon his retirement, Dr. Jacob Bubis was honored at a dinner given by the Mount Sinai Hospital Board of Trustees. The Board also announced establishment of a traveling fellowship at the hospital in honor of Dr. Bubis which will be used to send one or more residents annually to other metropolitan centers for additional training.

Williamsburg—At the Williamsburg Homecoming in July, Dr. J. P. Allen was honored for his more than a half century of service to the community.

DERMATOLOGIST wishes location, association or appointment. Woman, aged 30; board eligible; excellent training with M. S. in Dermatology. Available immediately. Box 788, c/o Ohio State Medical Journal.

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Hillsboro — Dr. Esther Marting, Cincinnati, spoke before the Highland County Chapter of the American Cancer Society meeting on September 14.

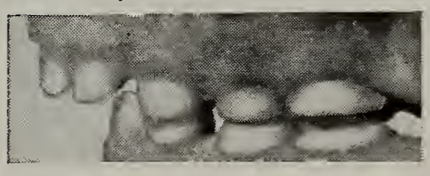
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Renal Function, edited by Stanley E. Bradley, M. D., ($3.00. *The Josiah Macy Jr. Foundation, P. O. Box 575, Packanack, N. J.)*, is the publication of Transactions of the Fourth Conference on this subject, sponsored by the Foundation. It deals with ion exchange, cation exchange, water and ion movement.

The Hepatic Circulation and Portal Hypertension, by Charles G. Child, III, M. D., ($12.00. *W. B. Saunders Co., Philadelphia 5, Pa.)*, considers the portal venous system as well as the intimate circulatory dynamics of blood flowing to and from the liver. It attempts to close the gap in time between the discoveries of basic sciences and their clinical application to diseases of the liver.

The Self in Psychotic Process, by John Weir Perry, M. D., ($5.00. *University of California Press, Berkeley and Los Angeles, Calif.)*. The psyche, like the body, is an extremely historical structure. The book gives an excellent picture of the psychical contents of the disturbed mind. Its author tries by means of a knowledge of primitive psychology, folk lore, and mythology to understand what the psychotic is trying to say.

Nash's Surgical Physiology, Revised by Brian Blades, M. D., ($12.50. *Charles C. Thomas Co., Springfield, Ill.)*. In older days surgeons were strictly anatomists, but today the surgeon continually applies more physiological knowledge to his daily tasks than he is even aware. The original purpose of this text is retained in that it is designed to present briefly and simply those aspects of physiology which are of special importance to the surgeon. It is therefore a book which should be studied by everyone doing surgery and it certainly should be in every intern library.

Dizziness—An Evaluation and Classification, by David Downs DeWeese, M. D., ($2.75. *Charles C. Thomas, Pub., Springfield, Ill.)*. An excellent attempt to resolve the confusion that exists in the minds of most of us regarding the subject. Hence the value of a workable classification such as the author presents, and the interest he shows in the broader aspects of the subject.

The Integration of Behavior, Vol. II—The Integrative Process in Dreams, by Thomas Morton French, M. D., ($6.50. *University of Chicago Press, Chicago 37, Ill.)*. Extends the author's attempt to map out the unconscious and conscious patterns on which human behavior is based. In this volume, the author develops a new method of analyzing dreams and in his description of the method, he really tells the reader what the analyst is doing when he interprets dreams. Illustrated by scores of dreams which are idexed by subject, it becomes the physician's "dream book."

The Adaptive Chin, by E. Lloyd DuBrul, D.D.S., and Harry Sicher, M. D., ($3.50. *Charles C. Thomas, Pub., Springfield, Ill.)*, is a simple story to show what science knows and history can safely deduce about the development of the chin. In short, it is represented as an adaptation to the assumption of the erect position rather than the mythologic cultural achievement of a superior race and individual.

Add Life to Your Years, by Ernst Philip Boas, M. D., ($3.75. *The McBride Co., Inc., New York 16, N. Y.)*, tells how to overcome the physical handicaps which often but not necessarily come with advancing years and to meet the mental and other readjustments to bring and maintain happiness. Written by a physician who believes that his patients should have a knowledge of their condition so that they may give him intelligent co-operation.

Ear, Nose and Throat Diseases for Medical Students, by William McKenzie, ($5.50. *E. & S. Livingston Ltd., Edinburgh and London;* United States distributor, *Williams & Wilkins Co., Baltimore 2, Md.)*. Aimed at the British medical student late in his training, it aims to stimulate rather than to be exhaustive. Well written—excellent for the American student and for review of the subject.

Cell Chemistry, edited by Dean Burk, ($7.50. *Elsevier Press, Inc., Houston 6, Texas)*. A collection of papers dedicated to Otto Warburg on the occasion of his 70th birthday. These technical papers are of high order as befits the honor of a Nobel Prize winner.

The Art and Science of Nursing, by Ella L. Rothweiler, Jean White, and Doris Geitgey, ($5.00. Fifth Edition. *F. A. Davis Company, Philadelphia, Pa.)*. A new edition of this standard text which continues to emphasize that patients are people and need to be treated as human beings.

Histopathologic Technic and Practical Histochemistry, by R. D. Lillie, M. D., ($7.50. *The Blakiston Co., Inc., New York 22, N. Y.)*. An encyclopedia of the subject based upon skill and experimentation.

Song of Life With Variations, by H. Ameroy Hartwell, M. D., ($5.00. *Bruce Humphries, Inc., Boston 16, Mass.)*. A collection of works by a busy physician who likes to amuse while he

instructs. Outstanding are the articles on "What's Wrong With Me?," "The Eight Little Sinners," and "Dust of Our Times." You will enjoy it and so will your patients.

Know Your Doctor, by Leo Smollar, M. D., and Neil Morgan, ($3.00. *Little, Brown & Co., Boston 6, Mass.),* concerns itself with the attitudes of patients toward their illness and of doctors toward their patients. The author makes liberal use of illustrative case histories. The book has been written primarily to allay the fears of people frightened by current articles in the press.

Energy Metabolism and Nutrition, by Raymond W. Swift, and Cyrus E. French, ($5.75. *The Scarecrow Press, Washington 7, D. C.),* brings together the various methods of calorimetry and points out the applicability and limitations of each in modern nutritional science.

Eat, Think and Be Slender, by Leonid Kotkin, M. D., ($2.95. *Hawthorn Books, Inc., New York 11, N. Y.).* An attempt to make the obese person understand why he is fat and to impress upon his mind that he must have the cooperation of his physician. Then, the dieter is not starved. The author insists that the fat person should not begin with a feeling that he must go hungry. Before he goes on the diet, he must understand that he is going to get enough to eat, but there are certain foods which he must not eat. Hence, the title of this workable manual.

Health for You, by Katharine B. Crisp, ($3.40. *J. B. Lippincott Co., Philadelphia 5, Pa.).* In effect, this is a complete revision of the author's text, **Be Healthy.** Based on the experience of the wide use of that book throughout the high schools in the nation, the author has given us what is essentially a new textbook in health education.

A Primer of Cardiology, by George E. Burch, M. D., F. A. C. P., ($5.50. Second Edition. *Lea & Febiger Co., Philadelphia 6, Pa.),* intended as an introduction to cardiology, the reception that previous editions have received, is a recommendation for this new edition.

Lesions of The Lumbar Intervertebral Disc, by Glen Spurling, M. D., ($4.75. *Charles C. Thomas Co., Springfield, Ill.).* This text deals with the subject, with special reference to the rupture of the annulus fibrosus, with herniation of the nucleus pulposus. The book correlates the pertinent anatomical and physical aspects of disc lesions with the clinical side, and outlines their management.

The Emotional Problems of Children; A Guide for Parents, by Harry Joseph, M. D., and Gordon Zern, ($3.75. *Crown Publishing Co., New York 16, N. Y.).* A straightforward guide, bringing the experience, perspective, and wisdom of the director of the Guidance Center of New Rochelle, N. Y., to the parent who is really interested in trying to give to his child the tools and the courage to face life and enjoy it. It contains the answers to literally scores of definite problems, beginning with the first year of life and going through adolescence. It is truly encyclopedic in character, in that there seems to be no question a parent could ask about his child's behavior which does not find an answer in this book (and the index is complete—making the book worth ever so much more).

Arthritis and Rheumatism, by Charles L. Steinberg, M. D., with five contributors, four of whom are from the Rochester General Hospital, and Dr. E. W. Lowman, Assistant Professor of Medicine at New York University College of Medicine, ($10.00. *Springer Publishing Company, Inc., New York, N. Y.).* This book gives a workable account of current knowledge of arthritic and rheumatic diseases and their variations. It presents the most promising methods of therapy known today. It focuses upon the problems and situations of daily practice. The recommended method of treatment makes use of any mode of attack that offers any promise.

The Historical Roots of Learning Theory, by Horace B. English, ($0.65. Doubleday Papers in Psychology, *Doubleday & Co., New York 22, N. Y.).* This is an attempt by a professor of psychology in the Ohio State University to present, in twenty pages, those historical facts that will help us understand our own beliefs and half-beliefs about how men learn.

Peripheral Circulation in Man, edited by G. E. W. Wolstenholme, and Jessie S. Freeman, ($6.00. *Little, Brown and Co., Boston 6, Mass.).* A CIBA Foundation Symposium arranged in succession to the one held earlier on visceral circulation. The book covers the methods for studying blood flow, the changes in circulation due to exposure to cold and heat, the action of adrenalin and noradrenalin on blood flow, the neurohistology of circulation, and the effects of sympathectomy, the significance of cold agglutinins, and the influence of visceral activity on the peripheral circulation.

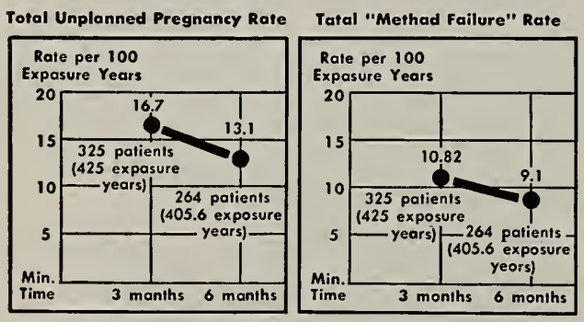
The Work of WHO, 1952, Annual Report of the Director-General to the United Nations. ($1.25. Sale Section, Palais des Nations, Geneva, Switzerland, or *Columbia University Press, International Documents Service, New York, N. Y.).* According to this report, after six and one-half years of developmental effort, the Secretariat may now be said to have welded itself into an integrated and balanced instrument for carrying out the intentions of the World Health Assembly and of its executive board. For those who are interested in the workings of any of the United Nations agencies, especially those of us who are interested in social and preventive medicine, but may be in disagreement as to how to instrument it, this is a very informative and helpful work.

PSYCHOLOGIC MOTIVATION AND CONCEPTION CONTROL

Psychologic motivation, defined as "... the sincere, urgent, uncomplicated desire to remain nonpregnant..." is an increasingly recognized factor in the success or failure of contraceptive measures.[1]

One of the factors influencing motivation, namely, parity, was appraised by Guttmacher[1] and associates in a three-year study of the jelly-alone [RAMSES® VAGINAL JELLY] method for contraception. A carefully selected group of 325 postpartum clinic patients used RAMSES VAGINAL JELLY for periods representing a total of 425 patient years of exposure. The technic showed marked effectiveness but was especially successful "among patients of lower parity."

Although the method was highly dependable, some unplanned pregnancies did occur. The pregnancies were divided into "patient failures" and "method failures." Patients readily admitting omission or irregular use of the jelly were classified in the first group, while those claiming regular and faithful use of the jelly were grouped in the latter category.



Comparison of conception control with RAMSES VAGINAL JELLY in patients using the method for 3-36 months and 6-36 months.[1]

During 425 patient years of exposure in 325 women using the jelly, the total unplanned pregnancy rate was only 16.7 per 100 patient years of exposure. When the "method failure" for the entire group is calculated, the unplanned pregnancy rate drops to 10.82 per 100 patient years of exposure. When only those patients who used the jelly-alone technic for six months and longer are considered (the usual length of time accepted for valid comparisons) the pregnancy rate is decreased markedly. This indicates that familiarity with and reliance on the method are probably also important. In 264 such patients, during 405.6 patient years of exposure, the total unplanned pregnancy rate was only 13.1 per 100 years of exposure, and the method failure rate dropped to 9.1 per 100 years of exposure.

Fitting the method to the patient

It has been demonstrated that motivation, parity, and patient-intelligence play important roles in the selection and the successful use of a conception control method and, therefore, that the final decision regarding the selection of method must be left to the physician who is fully cognizant of all these points.

When in the judgment of the physician, parity, anatomic factors, or motivation indicates the use of the diaphragm-and-jelly method of contraception, the RAMSES® TUK-A-WAY® Kit is recommended. The RAMSES® diaphragm is flexible and cushioned — provides an optimum barrier and utmost comfort. In combination with RAMSES jelly it offers an unsurpassed contraceptive technic. Both products are **accepted by the appropriate Councils** of the American Medical Association.

*Active agent, dodecaethyleneglycol monolaurate 5%, in a base of long-lasting barrier effectiveness.

1. Finkelstein, R.; Guttmacher, A., and Goldberg, R.: Am. J. Obst. & Gynec. 63:664, Mar., 1952.

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423 West 55th Street, New York 19, N.Y.

The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 50 November, 1954 No. 11

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The Treatment of Acute Barbiturate Poisoning*

NICHOLAS MICHAEL, M. D., and CALVIN L. BAKER, M. D.

DEPRESSED and other mentally ill patients will at times attempt suicide by ingestion of some type of barbiturate, other sedative, or narcotic, depending on what drug is within reach at the moment. Some will make serious attempts by taking large amounts, after days or even months of planning and accumulating the drug over long periods of time. Others will take an overdosage of a few capsules on a hysterical impulse from whatever cause or from inability to sleep. The average patient does not know the amount necessary to cause death and is likely to err in not taking enough. The seriousness of the overdosage depends not only on the amount of the drug ingested but on how soon after ingestion the patient is discovered.

Prior to the use of the electrostimulator a neurotic patient made three attempts at suicide by taking barbiturates. Immediately after taking the drug she sought help. As a result she was rushed to the hospital, had her stomach washed and sent back home. On the fourth attempt following the same pattern, she stopped at a drug store and bought and took some barbiturates. She rushed home in a taxi expecting to find her mother. Her mother did get home about six hours afterwards. The patient died the next day in spite of every effort to revive her.

SIGNS AND SYMPTOMS

The symptoms of acute barbiturate poisoning are variable depending on the sensitiveness, amount, and time of discovery after taking the drug. Some patients are more tolerant than others. Respirations may be shallow and low. The pulse weak and below normal. Those in deep coma may be cyanotic. The temperature can be below normal or elevated. Pulmonary edema is not uncommon. Nystagmus is present in light coma. The corneal and gag reflexes are absent in deep coma. Pupils may not react to light, may be dilated or constricted. The deep reflexes are absent and occasionally a Babinski sign will be present. Toxic psychosis is common as the patient recovers.

FREQUENCY

Attempts at suicide with barbiturates are numerous. Many cases are not reported and no true statistics are available. Isbell[1] estimates deaths at 1500 a year in the United States—an 8 per cent mortality of all persons. Many more deaths are probably caused by the combination of alcohol and barbiturates but classed as deaths

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- Dr. Baker, Columbus, a member of the staffs of White Cross, University, and Grant Hospitals, is associate professor of psychiatry at Ohio State University.

*From the Department of Neurology and Psychiatry, White Cross Hospital, Columbus, Ohio. Read before the Ohio Neuropsychiatric Association meeting April 12, 1954, Columbus, Ohio.

due to alcoholism. Barbiturate poisoning is the most common type treated in general hospitals.

METHODS OF TREATMENT

Prior to the introduction of the Reiter electrostimulator, the treatment of acute barbiturate poisoning consisted of the use of large doses of analeptic drugs such as metrazol,® picrotoxin and coramine.® Metrazol® was found to be safe. This drug can be injected intravenously as often as is necessary without ill effects. Twenty cubic centimeters of 10 per cent solution every 10 to 15 minutes may be used depending on the depth of coma.

Mousel[2] says that analeptics may be useless and may cause harm. He recommends the use of salt poor serum albumin. This he states is used to correct the cerebral anoxia by eliminating cerebral edema. We agree with Richards and Kappanyi[3] in that there is a wide margin of safety in using metrazol.® Locket and Angus[4] recommend adequate airway by careful attention to the tongue and mouth and above all constant attendance of a nurse. They did not consider laryngeal intubation as necessary.

THE ELECTRIC STIMULATOR

Robie[5] was the first to use the Reiter electrostimulator in barbiturate poisoning. The minimal dosage of undirectional electric diencephalic stimulation has been found to elevate the blood pressure, increase the depth of respiration and improve the quality of the pulse. In our opinion the electrostimulator maintains the individual alive until the body has a chance to destroy the barbiturate.

We do not believe, as it was thought at first, that the current destroys the drug. Relapses into a deeper coma will sometimes occur if the treatment is discontinued. The electrostimulator maintains life and gives the body a chance to destroy the drug. Normal saline intravenously was found to be sufficient in the replenishment of fluids. Glucose has been eliminated. Verbal reports indicate a possible synergistic action between glucose and barbiturates.

CASE DISCUSSION

Patients in this series of 15 cases of acute barbiturate poisoning were treated with the Reiter electrostimulator. Of this group, seven were considered to be in serious condition. In general the stomach was washed routinely if the patient's condition permitted. Individuals in serious condition were taken directly to their rooms in the hospital, a rubber airway placed in the mouth and the electrostimulator applied. Intubation was done in some cases where the airway did not insure free passage of air in and out of the lungs. Oxygen was available and utilized whenever the breathing seemed shallow and the patient was cyanotic. Large doses of metrazol® where available. A doctor or a nurse, instructed in the technic of using the electrostimulator, was in constant attendance.

REPORT OF CASES

Case 2. Female, age 67, married. History revealed she had a cerebral hemorrhage followed by a left-sided hemiplegia about two years before. She was in bed and practically helpless since that time. She took "a handful of sleeping pills" the night before but was not brought to the hospital until the following afternoon. Consultation was requested 24 hours after admission or approximately 40 hours after ingestion of the sleeping pills. The electrostimulator was applied for four hours but the patient did not improve and died the next day.

In this case the interval between ingestion and treatment was too long. The electrostimulator should have been used indefinitely. In view of the patient's physical condition prior to the taking of the barbiturates permanent damage to the brain had probably taken place.

Case 4. Female, age 44, married, gave a history of feelings of inadequacy throughout her life. Two months before she gave birth to her first baby. Following the birth of her baby she became depressed and felt that both her husband and the baby would be better off without her. She thought the baby deserved a better mother. She took twenty 1/4 gr. tablets of morphine and seven 1½ gr. of seconal® about 1:00 a. m. The husband found her unconscious about 7:00 a. m. but did not get alarmed until 9:00 a. m.

On admission to White Cross Hospital, she was cyanotic and cold. The intern could not get the pulse. He was not sure he could hear heart sounds. The blood pressure did not register. The respirations were shallow, about eight per minute. After the application of the electrostimulator the pulse became perceptible and the breathing deep and more frequent. The blood pressure registered 85/40 within a half hour, 90/40 within an hour, 110/62 within one and one-half hours, and 117/68 at the end of three hours. At 3:00 p. m. 5 cc. of metrazol® were given intravenously and repeated at 10 minute intervals for a total of 25 cc. At 4:00 p. m. the patient was out of danger. The electrostimulator was used for 6½ hours. Period of unconsciousness before stimulator was applied, 8½ hours.

She showed no signs of toxic psychosis but the next day she seemed very depressed. A course of electric shock therapy followed by psychotherapy brought about a remission. At the end of the treatment the patient was a well adjusted and contented mother, happy to be alive.

Case 5. Female, age 5 years. This patient took an undetermined amount of "grandma's sleeping tablets" and was found unconscious in bed. The emergency squad reported she stopped breathing in the ambulance and the resuscitator was applied. Analeptics and stimulants given by the resident staff did not help. The breathing was shallow and the pulse 186. The condition of the patient noticeably improved with the use of the electrostimulator. Total time of application of stimulator, 8 hours. Period of unconsciousness before use, approximately 2 hours.

The next day the patient was up and about, playing with the other children. There was no evidence of toxic psychosis. She left the hospital

within 44 hours after admission mentally cleared and none the worse for her experience.

Case 8. Female, age 54, single, with a history of periodic attacks of depression, was in another attack of depression when she took about 30 grs. of seconal® and a large number of ipral® tablets. She took the tablets about 2:00 a. m., but was not found until 8 o'clock in the morning. On admission to the hospital there was an attempt at stomach washing without results. She was given picrotoxin and coramine® without results. Consultation was sought and the use of the electrostimulator was started about 5:30 p. m.

The patient ran a stormy course, at times becoming apneic, at others cyanotic. Metrazol® was used at intervals. The electrostimulator, after its continuous application of 6½ hours, was used 45 minutes out of each hour for a total of 48 hours. Coma prior to the use of the stimulator, 15½ hours. The patient was in a coma for a total of 120 hours. She was very depressed when she came out of the coma and was transferred to a private sanitarium because of the threat of further attempt at suicide.

Case 11. Female, age 48, married. This patient had a radical right mastectomy for cancer of the breast a year before. She complained of severe pain in the area of the scar and of headaches. She had always been an intense, self-conscious and sensitive individual. She could not sleep and no medicine could help her. She took an undetermined amount of barbiturates and was found unconscious by her husband on his return from work late that evening.

On admission to White Cross Hospital the patient was cyanotic and the pulse 104. The pupils were pinpoint and the reflexes were absent. Because of the difficulty in breathing, an endotracheal tube was inserted. Metrazol,® a total of 50 cc., was given intravenously. The electrostimulator was used for 31 hours. Time of coma prior to use of stimulator not known. She was found to be very depressed and a course of electric shock therapy was given with good results.

None of the patients treated with the electrostimulator developed toxic reactions. On awakening, they were cooperative and talked frankly and coherently. Most patients could have gone home within 24 hours after termination of the coma. This was in marked contrast with individuals treated by other means. Such patients became delirious, restless, noisy, belligerent and difficult to control. Restraints, besides constant attendance, were necessary for a period of five or more days depending on the particular case. It presented a problem in a general hospital especially since further sedation was inadvisable.

In some cases the electrostimulator was utilized mainly to prevent toxic reactions. In one case it was used to help terminate a toxic reaction with good results. None of the patients showed any brain damage, (with a possible exception of the one who died), even though some were in prolonged coma.

CONCLUSION

In the treatment of acute barbiturate poisoning, the use of the electrostimulator, with judicious use of analeptics and adequate airway is superior to all other forms of treatment and offers the best results.

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Normal Duties Best For Emotional Employee

Attending physicians can play a major role in assisting emotionally disturbed employees to get readjusted in their places of employment. By giving the employees sound advice and counselling employers on proper placement of the upset employee, the doctor on the case or the physician-consultant to the industry can be a real help in efforts to meet an important employment problem. A recent experiment in a du Pont plant reveals some good suggestions on this subject.

Coddling is not always the best way to help the emotionally-disturbed employee. Sometimes he will get well sooner if required to accept the normal responsibilities of his job and to perform like other workers in his group. That is the conclusion of Dr. Gerald Gordon, psychiatirist, of E. I. du Pont de Nemours and Co., following a four-year experiment in one of the Company's plants.

During the four years, seven per cent of the plant's employees were treated. As employees, most of them had been "difficult." They had more accidents than the average. They were absent oftener. They visited the dispensary more frequently and took up more time of the physicians, nurses, supervisors and shop stewards.

Except for those with some serious organic ailment, patients were sent back, after diagnosis, to full regular duty on the same job. Supervisors were briefed on the proposed treatment and asked to cooperate by requiring the patient to live up to his full responsibility.

Where supervisors cooperated, the patient was helped. On the other hand, "where supervision failed to follow the medical recommendations and insisted on coddling and appeasing the employee," Dr. Gordon reported, "failures usually resulted."

As patients improved under treatment—either medical or supervisory—their absenteeism rate dropped, accidents were reduced and their personnel difficulties declined. Two-thirds of the entire group remained with the company. About half of these were considered by management to have improved.

Occupational Diseases

THOMAS F. MANCUSO, M. D., M. P. H.

IN Ohio the industrial population comprises 2,300,000 workers who are potentially subject to occupational diseases and industrial public health hazards resulting from exposure to toxic substances in their working environment. These diseases may be of a serious nature affecting the various vital organs and systems of the body, depending upon the nature of the toxic dusts, fumes, mists, vapors, or gases and the concentrations involved. In general a broad classification of occupational diseases due to physical and chemical agents may be grouped into the following four categories:

(1) Toxic dusts, mists, fumes, vapors and gases;
(2) Physical states of the environment such as temperature, radiant energy and noise;
(3) Mechanical factors such as pressure, physical strain and movement, and
(4) Infectious agents connected with industrial occupations.

SCOPE OF OCCUPATIONAL DISEASES

Chemicals may be absorbed through the skin, inhaled through the respiratory tract or taken through the digestive tract due to contamination at work from improper work processes or due to lack of adequate cleaning facilities and personal protective measures. Chemicals in general vary in their toxicity; their effects may be acute or chronic and may affect one or more organs at different times. We know, for example, that silica, asbestos and beryllium produce changes in the lungs with physical disability of long or permanent duration.

Benzol, toluene and other solvents produce diseases of the blood and blood-forming organs. Carbon tetrachloride, tetrachlorethane and other halogenated hydrocarbons produce toxic effects on the liver and kidneys. Manganese, mercury and carbon disulphide affect the brain and central nervous system.

Some chemicals may produce specific cancers such as cancer of the bladder due to aromatic amines. Destructive changes in the bone have occurred due to arsenic and phosphorus. Perforations of the nasal septum as well as lesions of the oral cavity result from excessive exposure to chromium, alkalies, and acids. The gastrointestinal tract is affected symptomatically by chemicals capable of acting as systemic poisons.

Gases such as carbon monoxide, phosgene and cyanogens cause asphyxiation, while other gases such as nitrous oxides produce chemical pneumonias. Exposure to x-rays and emanations from radium may produce serious burns and cancer while the blood and blood-forming organs are also profoundly affected by radiation. Infrared rays may produce cataracts and methyl chloride, blindness.

Occupational dermatoses are the most frequent of the industrial diseases and result from exposure to chemicals which act as primary skin irritants or as skin sensitizers. Incidentally, it is characteristic of this dermatitis that the symptoms disappear when the person is taken away from the working environment and usually reappear on re-exposure unless preventive measures have been taken.

OCCUPATIONAL EXPOSURES

The magnitude and complex nature of the occupational disease problem is reflected in the number, variety, and location of industries. There are over 12,500 manufacturing industries utilizing hundreds of varied chemicals and materials which require exposure of individuals to toxic dusts, fumes, vapors, mists and gases and other factors evolved during the manufacturing processes. Ohio leads the nation in the production of steel and glass and in the number of foundries as well as electrical appliances and the ceramic arts. The state is noted for its wide variety of manufactured products and industries in all sections of the state.

The State of Ohio has a rather remarkable distribution of industries both large and small within its various counties and there is hardly an area which does not have some form of industrial employment. In this respect practically every physician has, within the area he lives and practices, an opportunity to study and observe individuals who have been afflicted with occupational diseases. Even agriculture presents important occupational health problems through the wide-spread use of chemicals in the spraying of crops and the various insecticides. Lead, arsenic, nicotine and DDT have been commonly recognized but the recent increasing use of organic phosphates such as "parathion®" and

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● Dr. Mancuso, Columbus, is chief of the Division of Industrial Hygiene, Ohio Department of Health.

Presented April 13, 1954, before the Section on General Practice at the Annual Meeting of the Ohio State Medical Association, in Columbus.

"TEPP" (tetraethylpyrophosphate) have been dramatic and deadly in their toxic effects. Occupational diseases then may occur under a variety of conditions and in a tremendous number of different environmental exposures.

We know that 98.6 per cent of all the manufacturing industries in the State of Ohio, exclusive of transportation, agriculture, construction, etc., have 1,000 or less employees. Generally speaking, small industries do not have adequate medical service. This is particularly true of industries with less than 500 employees.

The lack of medical services represents a tremendous need, long recognized, which requires a co-ordinated effort for improvement. Unless there be physicians to take care of the employees and proper arrangements made for satisfactory medical services, occupational diseases can neither be recognized nor controlled. Basically, the foundation for the prevention and control of occupational diseases relates to the provision of adequate medical services to these industries.

RESPONSIBILITY OF PHYSICIAN, PATIENT, EMPLOYER, AND COMMUNITY

The physician has a responsibility to his patient for the correct diagnosis of an occupational disease. The recognition of an occupational disease not only affects the prognosis but also may modify the course of treatment. Under certain conditions further work might prolong the exposure and therefore aggravate the illness whereas removal from work may result in prevention and cure. Similarly certain specific industrial diseases have contraindications or requirements such as alcohol, for example, which will adversely affect an individual who has been exposed to carbon tetrachloride, and atropine which is a necessary emergency treatment for insecticide poisoning due to parathion.®

If the physician recognizes as the etiologic agent certain solvents like carbon tetrachloride, or other chlorinated hydrocarbons, he can estimate the damage to the liver or kidneys as well as the disability, and he can then determine the choice of treatment of the occupational disease. The proper diagnosis and treatment of an occupational disease also helps a patient financially in the sense that all occupational diseases are covered by compensation in Ohio, and the medical cost, treatment, diagnostic tests, hospital bills, etc., are paid by the Industrial Commission when the proper claim application has been filed and approved on a particular worker.

COMPENSATION

An occupational disease according to the industrial compensation board is "a disease peculiar to a particular industrial process, trade, or occupation to which an employee is not ordinarily subjected or exposed outside of or away from his employment."

All claims for occupational disease must be filed within six months after disability begins. In the case of claims filed for silicosis or any other disease of the respiratory tract, the application must be made to the Industrial Commission within one year after total disability began or within six months after death occurred. The payment for medical services is arranged according to a fee schedule established by the Industrial Commission in cooperation with a committee of the State Medical Society. This knowledge by the physician removes the financial barrier from a patient and enables him to remain under treatment with a doctor as long as necessary but morally, no longer for a particular occupational disease.

Unfortunately, few physicians have a personal acquaintance with the working environment of their patients. The symptoms of lead colic and acute appendicitis for example can and have been confused, but a physician with a knowledge of the lead exposure of his patient would be in a better position to evaluate his illness. Again, we find maganese poisoning and multiple sclerosis have twin-like symptoms. How many physicians would look for manganese poisoning in a patient employed in the manufacture of dry batteries? It is necessary for the physician, therefore, to obtain an accurate occupational history from workers who become their patients.

The patient in turn has a responsibility to the physician to provide him with complete and accurate data of his work as well as the reporting of all his symptoms and the factors relating to the illness. In short, every time a working man goes into a doctor's office when he is being treated for an illness, he should provide the doctor with some information about his occupation. the number of years he was employed at that type of work, the materials he handles and the substances to which he is exposed. The doctor then would include this information on the worker's case history card. It is because this information is seldom given to the doctor that difficulties have occurred and occupational diseases pass unrecognized. The patient should bring the work place to the doctor.

The physician has a responsibility to his industrial employer to provide adequate physical examinations on employees referred to him. This is of financial importance to the company in the sense that cursory examinations may pass over the recognition of a physical condition or preexisting disease with the consequence that the individual may be employed and the disease further aggravated by employment. Under such conditions the company is then subject to compensation costs for any disease or illnesses which result from the aggravation of any previous condition.

The most obvious considerations in this regard are diabetes, syphilis, and heart disease. Actual cases have occurred with considerable damage

to the individual as well as considerable financial loss to the company. The loss of a foot or leg in the diabetic and nonhealing fractures of a syphilitic are two illustrations which emphasize the necessity of adequate examinations. At the same time in the conduct of these physical examinations, the physician must keep his records confidential on a proper physician-patient relationship and not release information without the consent of the patient he has examined. It is for this reason that physical examinations are usually classified in four broad categories: A, B, C, and D, which relate to the selective placement of the employee according to certain types of work.

The physician must also guide management in the establishment of proper employment policies concerning individuals who are handicapped, those who have had tuberculosis or venereal disease, and problems of maternity and women in industry in regard to their proper placement. Certain basic principles relating to these employment policies have been expressed by national organizations in these fields. It is equally necessary for the physician to keep adequate records of these physical examinations as well as the diseases, injuries, and deaths of workers for current and future reference.

The recognition of an occupational disease by the physician is a basic necessity before he can seek to determine the cause and undertake preventive measures in order that other cases may not occur. By isolating or controlling the problem the physician decreases compensation costs and maintains production for the employer. The direct and indirect financial loss due to training of new personnel, interruption of production or loss of experienced employees in small plants has real meaning to the plant owner. Such an effort by the physician also facilitates a favorable public response to the plant in establishing it as a "safe" place to work.

The employer in turn has a responsibility to the physician in designating to him the proper authority and responsibility to insure that there will be no infringement of medical ethics or prerogatives. Also, the employer should provide the physician with authentic information about the toxic substances used in the industry which may affect the employees, their identification, quantities involved, and subsequent changes in manufacturing processes which may occur involving toxic substances. The plant physician should be provided with an opportunity to study the plant processes and the necessary First Aid facilities or personnel, and he should be given remuneration necessary to perform industrial medical services of a higher caliber.

The physician has an important responsibility to the community for the prevention of a disability or illness which may result in an economic loss, whether due to injury or sickness, for this in turn decreases the ultimate financial responsibility of a community to maintain people who are unable to work.

LEGAL REQUIREMENTS

The responsibility of a physician in the prevention and spreading of a communicable disease such as diphtheria or small pox is well recognized. Here, assistance is given to the community by the reporting of the communicable disease to the local health officer with the subsequent identification of the carrier or source of contamination and means of spread. These are dramatic and evident means of prevention through the efforts and cooperation of the general practitioners. We have exactly the same situation in regard to occupational diseases with the exception that only in unusual circumstances will they occur in epidemic fashion. However, the responsibility of the physician is a legal one which was established in 1920 by the General Assembly of the State of Ohio *"that every physician who is called in or attends a patient with an occupational disease is required to report the occupational disease within 48 hours to the State Department of Health on a form set up for that purpose."* (See accompanying form.)

These reports of occupational diseases which are sent to the Ohio Department of Health from all areas of the state form the basis for an epidemiological evaluation of the geographical distribution of diseases, their type, the number, and the industries involved which are plotted as is done in communicable diseases.

An illustration of this point is the large number of occupational dermatoses which were found to be occurring in a particular city in Ohio. The occupational disease reports, however, did not come to our attention from the physicians but from the newspaper releases that an epidemic of dermatitis had occurred which resulted in a threatened strike at a certain plant. We were called in to determine the cause of the dermatitis and found it was due to a change in the glue process used in the manufacture of automobile seat covers. If there had been proper reporting of the occupational diseases in this instance, the problem would have been spotted on an epidemiological basis by the Ohio Department of Health, long before it became a major problem in the community causing a labor-management dispute in addition to the effect on the employees' health.

STATE ASSISTANCE

The physician by fulfilling his responsibility in the reporting of an occupational disease to the official state agency enables, then, the technical resources of the state to be placed at his disposal in the identification and correction of a problem. The State Health Department has a technical staff consisting of medical, engineering, and chemical units which conduct the necessary

FORM

CERTIFICATE OF INDUSTRIAL OR OCCUPATIONAL DISEASE

WRITE PLAINLY WITH INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. The exact statement of OCCUPATION is very important. Physicians should state DIAGNOSIS in plain terms. See instructions on back of certificate.

2-17627

OHIO DEPARTMENT OF HEALTH
COLUMBUS 15, OHIO

CERTIFICATE OF INDUSTRIAL OR OCCUPATIONAL DISEASE

Name of Patient _____
(Last name) (First name) (Second name)

Address: Street and No. _____ City or Village _____

PERSONAL AND STATISTICAL PARTICULARS

Sex	Age	Color	Country of Birth

Single, married, widowed, or divorced (*write* the word) _____

OCCUPATION

(*a*) Trade, occupation, or work (in which disease was acquired) _____

Particular kind of work in such trade, etc. _____

Date of entering this occupation _____

Employer's name _____

Address _____

Employer's business (goods made or work done) _____

_____

(*b*) Previous occupations:

Name of occupations.	*Entered (year)*	*Left (year)*

Previous illnesses, if any, due to occupation:

Disease or illness	*Year*

MEDICAL CERTIFICATE OF DISEASE

Diagnosis _____

Chief symptoms and conditions _____

_____

_____

_____

Date first symptoms appeared _____

Complicating diseases (such as alcoholism, syphilis, tuberculosis, etc.) _____

_____

_____

What substance(s) or condition(s) in your opinion caused this affliction? _____

_____

_____

Duration (actual, estimated) _____
(Check which)

Additional facts _____

_____

_____

Date of diagnosis _____, 195__

(Signed) _____, M. D.

_____, 195__ (Address) _____

Mail to DIRECTOR OF HEALTH, Departments of State Bldg., Columbus 15, Ohio

For Instructions See Other Side

industrial hygiene studies. These studies comprise the evaluation of the manufacturing materials and processes; atmospheric determination of toxic dusts, fumes, mists, vapors or gases; measurements of illumination and ventilation; analysis of chemical composition of materials and processes to which the workers are exposed; evaluation of medical and nursing services in plants; necessary protective measures; and industrial toxicology.

Each type of industry and individual plant poses specific industrial health problems. In each instance of occupational disease, there are medical and engineering control measures which can prevent the occurrence of additional cases and can control the extent of the toxic exposures. The medical and engineering control measures required are designed for the specific process, operation, or toxic substance involved, in order that the maximum allowable concentrations be within the limits as specified by the regulations adopted by the Public Health Council in 1946.

The key solution to the prevention of occupational dermatitis, for example, is to keep the

contact of the irritants with the skin at a minimum. There are certain basic approaches to accomplish this and these are: (1) total enclosure of the manufacturing process, (2) adequate local and general exhaust ventilation, (3) protective clothing, (4) enforcement of cleanliness, (5) protective ointments, (6) the use of nonirritant industrial cleansers. In effect, then, the general practitioner has through the use of the state facilities a technical arm, so to speak, for use in the identification and control of suspected environmental factors within industry in order to carry out his responsibility to his patient, to his employer, and to his community.

A physician who suspects or recognizes an occupational disease and wishes to have technical assistance may request that help from the State Health Department.

"GROUP ASSOCIATION"

"Association" of factors from observations is manifest daily in the practice of medicine, especially when one correlates symptoms and physical findings in the examination of a patient. The "association" I wish to emphasize is that relating to a *group* rather than to one individual, such as a group of workers or a community at large. Perhaps a few illustrations will help:

Let us begin with an event in a small town where invitations were extended to attend a community supper. The meal was served on a Saturday evening and 4 to 8 hours later the people who attended became ill with nausea, diarrhea and vomiting. The doctor who was called to many of the homes recognized the symptoms of food poisoning. He discovered that all of the individuals had the same symptoms, all ate the same food at the same place and at the same time. The doctor *associated* the cause of the disease with the eating of this particular meal.

RELATING TO INDUSTRY

Now let us take an example of "association" relating to industry. We find workers cleaning out a tank with a solvent called carbon tetrachloride in a room that is not properly ventilated. A number of workers become ill and collapse. Since their work is the one common factor in their history, it is evident their illness is directly *associated* with their work.

These two examples or illustrations of "association" which I have described to you are immediately observed because they relate to an acute incident producing an acute disease, that is, the development of a disease or illness from a few hours to one or two days following exposure.

Let us now consider the chronic type of exposure. Some 200 men worked in a plant which manufactures chromates and about 12 to 15 years later a significant group of the men developed lung cancer and died. In another plant where dyes were manufactured, observations showed that 20 years later deaths from bladder cancer among the employees were far greater than one might expect. In neither case did the workers, their families or their physicians "associate" this particular disease or death with employment because of the so-called latent period, the long time it takes between occupational exposure and the actual development of the disease. This type of exposure then is frequently described as chronic and the development of disease and symptoms may be delayed weeks, months, or years after the occupational exposure occurred. Berylliosis, for example, may occur as long as 12 years after exposure.

There are difficulties too in this matter of "association." We realize there are hundreds of chemicals being used and introduced in various combinations in industry that may cause subsequent serious effects on the human body and that symptoms of disease may often develop months or years after the critical exposure. In addition, the last place of employment is not necessarily the work place where the initial exposure occurred. Individuals move from job to job as you well know, and the recognition of an "association" of such an exposure and the detection of the chronic disease which may develop requires comprehensive work histories and some knowledge of substances used in various industries.

MEDICAL PROGRESS

In closing, I should like to comment that some of you may have the opportunity of directing the medical services of an industry engaged in the manufacturing or processing of a single product or using a particular chemical in large amounts where a group of employees would be exposed to the same substance. If you would carefully record your observations of the symptoms and findings of these employee patients whom you examine, you may be able to make correlations of medical importance. This opportunity exists whether the observations relate to a large or small group of employees, or whether to a single department or an entire plant.

Undoubtedly many occupational diseases are classified as nonoccupational in origin and have been unrecognized by the patient, the employer, and the physician as well as the community.

It must be remembered that many contributions made to the progress of medicine were developed from the "initial association" of observations by the practicing physician which ultimately led to further scientific investigations and discovery.

Treatment of Vascular Headaches

E. J. BAXTER, M. D.

PROBABLY more than any other symptom, headaches require a great deal of ingenuity and patience, both in diagnosis and in treatment. Because they may occur as part of an illness, or as a syndrome per se, headaches cannot be treated only symptomatically. The entire patient, that is psyche as well as soma, must be considered. I have frequently encountered in my practice, patients whose chief complaints center on headaches.

In my experience, the most common types of vascular headaches are: Histamine cephalgia, migraine, and tension headaches.

DIAGNOSTIC CRITERIA

MIGRAINE

Three or more of the five cardinal points must be present:

1. Three-phase attack of recurring, throbbing, unilateral headaches.
2. Typical migraine personality.
3. Familial history of migraine.
4. No organic lesions.
5. Relief by ergotamine. DHE-45 has been found to be diagnostic of vascular headaches, in general, when used in adequate dosage early in the attack.

HISTAMINE CEPHALGIA

1. Unilateral headaches of short duration. Pain is constant, excruciating, burning and boring.
2. Commencing and ending suddenly.
3. Awakens patient at night; eased by erect position.
4. Attacks usually begin in later decades of life; more common in males.
5. Profuse watering and congestion of the eye on same side as headache.
6. Rhinorrhea and stuffiness of nostril; increased surface temperature of involved side.

TENSION HEADACHES

1. Pain is a pressure and band-like sensation described by a wealth of involved and complete descriptive terms.
2. Bilateral; pain not localized to any one area.
3. Pain not too severe, but may increase in severity toward the end of the attack.
4. No premonitions or aura.
5. No organic involvement.
6. Subjects are tense, emotional individuals, with attacks usually developing following stress periods.

The treatment of these headache syndromes can be divided into two phases; (a) active symptomatic relief for the acute attack; (b) prophylactic treatment for interval therapy.

The literature[1, 2, 3] starting with Wolff's original and classic studies, shows rather conclusively the effectiveness of ergotamine preparations for symptomatic relief. It is generally accepted that the pain of vascular headaches results from cranial vessel dilatation, and that the ergotamine, by constricting these vessels, aborts the pain and the attack. Caffeine combined with ergotamine tartrate (cafergot®) increased the vasoconstrictor action of ergotamine, making for a good oral preparation for effective symptomatic treatment.

The prophylactic management is more difficult. Psychotherapy, sedation, change of mode of living and habits, personality readjustment cannot be accomplished overnight. The use of histamine has greatly aided prophylactic procedures.

Horton first described histaminic cephalgia and its treatment by histamine desensitization. His results have been extremely encouraging with the following method :

"The contents of a 1 cc. ampul of histamine diphosphate (0.275 mg.) is equivalent to 0.1 mg. of histamine base. Ampuls of this character are now on the market. (All doses are given subcutaneously.) The quantity given at each injection is as follows: first injection, 0.25 cc.; second, 0.30 cc.; third, 0.35 cc.; fourth, 0.40 cc.; fifth 0.45 cc.; sixth, 0.50 cc.; seventh, 0.55 cc.; eighth, 0.60 cc.; ninth, 0.65 cc.; tenth, 0.70 cc.; eleventh, 0.75 cc.; twelfth, 0.80 cc.; thirteenth, 0.85 cc.; fourteenth, 0.90 cc.; fifteenth, 0.95 cc.; sixteenth, 1.00 cc.; seventeenth, 1.00 cc.; eighteenth, 1.00 cc.; nineteenth, 1.00 cc.; twentieth, 1.00 cc." Precautions are taken when flushing or any other symptoms of drug reaction develops.

The above dosage administered subcutaneously, is spread over a period of 10 days to 3 weeks. When the patient becomes free of attacks, maintenance treatment is begun with 0.275 mg. of histamine diphosphate administered 1 to 3 times weekly. Hansel[4] has modified this method in the following manner:

Subcutaneous injections of 0.1 cc. of 1/one mil-

Submitted March 11, 1954.

The Author

● Dr. Baxter, Sandusky, Ohio, is a member of the active staffs of the department of otolaryngology, Good Samaritan Hospital and Providence Hospital.

lion to 1/10 million solution of histamine are given at 3 to 4 day intervals. When response is obtained, the intervals between injection are increased. There is no change in dosage. Once the patient becomes free of attacks for an interval of 7 to 10 days, injections are discontinued until future attacks occur.

Kajtor[5] employed intense histamine therapy in chronic vascular headaches previously unresponsive to other medication. Twenty-one cases received histamine dihydrochloride by intravenous infusion of 3 to 8 hours duration every second day. Small doses (0.15 mg.) were employed at the start and increased gradually until 2.0 to 2.4 mg. were given, all diluted in 200 to 450 cc. of physiologic saline. With the infusion method, amelioration of the attack was temporary except for one patient, who was without headache for over one year. This investigator now employs a combination of infusions and subcutaneous injections to produce significant improvement in the patient's headaches.

Krueger employed subcutaneous injections of histamine azoprotein (1:10 dilution) administered every fifth day starting with 0.1 cc. and increased up to a 1.0 cc. dose for 10 injections, and then, 1 injection of 1.0 cc. weekly. If no improvement is obtained after 14 injections, the treatment is considered a failure. In a small series, 78.2 per cent with definite relief was reported.

In addition to histamine therapy, psychotherapy is greatly beneficial in producing and prolonging headache-free intervals. Recently, Hilsinger and Von Witzleben[6] reported the use of an autonomic drug which greatly aided prophylactic therapy. He found that the combination of ergotamine tartrate, bellafoline® and phenobarbital (bellergal®) will dampen the effects of undesirable autonomic impulses. This results in prolonging the quiescent period of frequently occurring vascular headaches.

METHODS OF TREATMENT

Outlined below is our method of treating vascular headaches:

A. Symptomatic Relief

1. DHE-45—0.5 to 1.0 cc. injected intramuscularly with 0.01 cc. of 1/1000 epinephrine as early in the attack as possible. Better results are obtained with the epinephrine added, and smaller doses of DHE-45 can be used.

2. Cafergot®—2 to 3 tablets as early as possible in attack. Prescribed for nocturnal attacks or if patient is unable to come to the office in time for a DHE-45 injection.

B. Interval Therapy

1. Allergic densensitization if specific allergen can be demonstrated. For example, we have found some patients who were allergic to house dust. These complained chiefly of "winter time" headaches, and rarely experienced attacks during the summer.

2. Histamine desensitization

(a) for allergic headaches that fail to respond to desensitization by allergen alone:

1. standard amounts and dilutions of the specific allergen

2. 0.1 cc. 1/1,000,000 solution histamine to 0.1 cc. 1/10,000,000

3. 0.1 cc. to 0.3 cc. DHE-45

—all in the same syringe.

(b) histamine and DHE-45 alone used for histamine cephalgia and migraine where no allergen is demonstrated and not of a known organic etiology. Better response to desensitization is obtained when a small amount of a vasoconstrictor is given with the histamine. NOTE: This dosage of DHE-45 has nothing to do with relief of acute attack. *Schedule of treatment:* An injection every four days until clinical response, i. e., the frequency of the headaches is diminished or stopped altogether. Then injections are spaced at weekly intervals, and as improvement continues, longer intervals should occur between injections. Finally, the dosage schedule should be monthly injections. The series is repeated if headaches recur frequently or with increased severity.

3. Psychotherapy and bellergal® if desensitization fails, or if headaches are obviously of psychosomatic origin.

4. Small doses of thyroid extract, frequently, are of value whether or not basal metabolic rate is normal.

5. Complete physical and neurologic examination by specialists when indicated.

RESULTS

I have been relatively successful in employing a modified histamine desensitization technique. The results are tabulated in table 1. No side effects have been observed with any of the treatments.

CASE REPORTS

The following case histories show our method of managing certain vascular headaches:

(1) **Migraine**—The patient, a ten year old male, had suffered migraine headache from the age of seven. The pain would begin in the center of the forehead and progress over the entire cranium. Gynergen® provided relief from the acute attack, but would leave a dull pain. Nausea and vomiting were frequent with occasional diarrhea. There was no history of hay fever, asthma, or nasal discharge. Tonsillectomy and adenoidectomy had been performed at the age of seven. Skin tests showed the boy sensitive to dust. Severe attacks occured at least once or twice weekly. The boy was well adjusted. There was no demonstrable relationship between the attacks and emotional stress. Both parents were well adjusted.

Treatment was started with 0.2 cc. of 1/10 million solution of histamine and 0.2 cc. of 1/one

TABLE 1

	Number Treated	No. Treated with DHE-45	Excellent	Good	Poor	No. Treated with Cafergot®	Excellent	Good	Poor	No Treated with Histamine Desensitization	Excellent	Good	Poor	No. Treated with Nicotinic Acid	Poor
Histamine Cephalgia	28	23	22	—	1	8	7	1	—	10	6	1	3	2	2
Migraine	32	22	18	4	—	9	6	1	2	10	7	3	—		
Tension Headache	14	11	10	1	—	6	2	3	1	5	5	—	—		
Total	74	56	50	5	1	23	15	5	3	25	18	4	3	2	2
			89%	9%	2%		65%	22%	13%		72%	16%	12%		100%
			98%				87%				88%				

Definition of Results:
Excellent Results—complete relief in ½ to 1 hour.
Good Results—attack greatly shortened and severity decreased.

billion solution of dust antigen. An injection was given every four days for a period of five weeks. The frequency and severity of the attacks markedly decreased. One cafergot® tablet usually provided symptomatic relief for the head pain. Prophylactic treatment was continued using 0.3 cc. DHE-45, 0.2 cc. 1/10 million solution of histamine and 0.2 cc. 1/one billion solution dust antigen for five additional injections 5-10 days apart. Attacks then became infrequent and an injection was given only when an attack occurred. Four injections in the next three months were necessary.

Follow-Up: The patient has been entirely free of attacks for a period of six months. A two month period was spent at a boy's camp with the occurrence of three minor headaches, one associated with a sore throat. A supply of the solution was sent to the camp doctor with instructions as to how to use, if necessary.

(2) **Histamine Cephalgia,** mild allergy demonstrated: Miss —.; daily headaches, typical histamine cephalgia, dust and mold scratch test positive. DHE-45 relieved acute phase.

Injection.	#1	Dust & Mold sol. #11	0.2 cc.
		DHE-45	0.4 cc.
		Histamine sol. #7	0.1 cc.
	#2	D. & M. #9	0.2 cc.
		Hist. #7	0.15 cc.
	#3	D. & M. #9	0.2 cc.
		DHE-45	0.5 cc.
		Hist. #7	0.15 cc.
	#4	Hist. #6	0.1 cc.
		DHE-45	0.4 cc.
	#5	D. & M. #9	0.15 cc.
		DHE-45	0.4 cc.
		Hist. #7	0.2 cc.
	#6	Hist. #7	0.1 cc.
		DHE-45	0.3 cc.
	#7	D. & M. #9	0.15 cc.
		DHE-45	0.3 cc.
		Hist. #7	0.1 cc.

Eight additional injections with number 7 solution were necessary for long term relief.

DISCUSSION

This report endeavors to show the methods employed by an otolaryngologist to diagnose and treat various vascular headaches.

Diagnosis follows the patterns and diagnostic criteria well established in the literature. The same can be said for symptomatic treatment. In our hands, DHE-45 and cafergot® produce excellent results in absorbing the acute phase of vascular headache attacks.

For prophylaxis, we have employed many methods. We have found that a combination of psychotherapy (discussion of patients' emotional and environmental problems) together with adequate doses of a drug which restores autonomic balance, aids greatly in prolonging quiescent periods in patients whose headaches are primarily psychosomatic. Histamine desensitization is very useful in cases of an allergic nature or in histamine cephalgia. With the combination of histamine or DHE-45 which we employ, we produce what we believe to be a "non-specific immunity" in which sensitization is destroyed through interference with an end product. Small amounts of histamine act as a vasoconstrictor, while large amounts produce the opposite effect. The drip method produces both effects, while our modification apparently produces only vasoconstriction and a definite cellular or humoral immunity in the responding patients.

In addition, I would like to point out the need of thorough physical examination, since in one instance, vascular headache disappeared following molar extraction; in another following removal of impacted cerumen, and in a third following the treatment of a toxicity which produced a hyperactive labyrinth.

The treatment of vascular headaches, can easily be successful with a flexible and varied but all-inclusive, mode of management.

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Fetal Salvage in Toxemia of Pregnancy

HYATT REITMAN, M. D.

IF a case of preeclampsia is to be managed with complete success, four major objectives must be attained. These are: prevention of maternal convulsions; prevention of maternal residual hypertension; delivery of a child which survives; and delivery with minimum trauma. In certain cases of preeclampsia, especially in patients near term, all four of these objectives may be served equally well by the same treatment, namely, prompt induction of labor. In other instances it may be virtually impossible to gain all four objectives.

For example, if a patient develops severe preeclampsia two or three months before her expected date of confinement, prompt termination of her pregnancy may seem indicated if the prevention of convulsions and residual hypertension is to be realized. This may result in the delivery of a nonviable premature infant. Most of the infant deaths in preeclampsia are due to prematurity as a result of the frequent necessity to terminate a pregnancy at an early date. In a study of 749 premature infants reported by Pomerance, toxemia of pregnancy was the most frequent of all maternal complications. Also, toxemia of pregnancy was responsible for the highest incidence of stillbirths.

THE EFFECT OF TOXEMIA ON THE LIVING PREMATURE INFANT

There has been much speculation as to the effect of severe maternal toxemia on the live born premature infant. Breese, in an analysis of 173 cases, is of the opinion that maternal toxemia has no influence on the ultimate survival of the offspring. On the other hand, Taylor and associates conclude that infants born of mothers suffering from complications of pregnancy, including toxemia, have a mortality rate 4 to 5 times as high as those born of normal mothers.

Diddle and Plass report on 160 infants born alive of mothers with toxemia of pregnancy. An analysis of their data does not reveal any significant difference in the neonatal mortality rate of these babies as compared with those born of nontoxemic mothers.

In the more severe grades of preeclampsia, the fetal mortality approximates 20 per cent. In 137 cases of severe preeclampsia which were recently reported by McLane, the gross fetal mortality was 17 per cent. Tillman states that the fetal mortality in preeclampsia is notably high. In his series of 50 cases reported from Sloan Hospital, 12 per cent of babies were either born dead or died within a few days. McLane reports a fetal mortality of 29 per cent associated with eclampsia. Tillman, in a series of 89 cases of eclampsia, had a fetal mortality rate of 51 per cent. In his series no living babies were obtained when convulsions occurred before the 36th week of pregnancy. At the 36th week 30 per cent living babies were obtained compared with 70 per cent living babies when convulsions occurred at term. Eastman states that the mortality for the child approaches 45 per cent in eclampsia.

Fetal prognosis in toxemia of pregnancy is important in determining the therapeutic management of the patient. A decision as to whether some risk should be accepted by the mother may well depend on the probability of a successful outcome for the baby. The occasion for a decision occurs at or soon after the 28th week when the period of fetal viability is being approached. At this time, and during the succeeding weeks, the problem narrows down to a determination of which of two risks for the fetus is greater, that from prematurity if labor is induced, or from intrauterine death if the pregnancy is permitted to continue.

PROGNOSTIC FACTORS THAT DETERMINE INTERRUPTION OF PREGNANCY

The prognostic factors which should determine this decision are several in number, and are difficult to evaluate. They include blood pressure, albuminuria, edema, time of onset of the toxemia, and the response to therapy. As far as the fetus is concerned, the prognosis depends more upon the week of onset of the preeclampsia than any other single factor. Actually, the fetal losses occurring per week seem about the same regardless of the duration of the disease. The high fetal loss in the cases developing early is due primarily to the fact that a threat to the life of the fetus which is relatively constant must be borne for more weeks.

Taylor states there is no evidence that the specific pathologic action of a long period of toxemia has cumulative effects on the baby.

The ideal treatment of preeclampsia is termination of the pregnancy. However, because the

Presented April 13, 1954, before the joint session of the section on obstetrics and gynecology and the section on pediatrics at the Annual Meeting of the Ohio State Medical Association, Columbus.

The Author

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baby may be premature the tendency is widespread to temporize in many of these cases in the hope that a few more weeks of intrauterine life will give the infant a better chance. In the milder varieties of preeclampsia such a policy is often justifiable, at least up until the 35th week of gestation.

The most difficult problem, as related to fetal salvage, is in the moderately severe preeclamptic patient between the 30th and 35th week of pregnancy. Urging a conservative approach, Adair states, "There are no absolute criteria for determining the best course for either the mother or the fetus." He concludes that usually the best outlook for both occurs when there is a natural onset of labor and that the risk to the fetus arises not from the toxemic state itself, but from the procedures used to terminate the pregnancy. Potter answers the question concerning the effects of the late toxemias on the fetus as follows: "In a mother who is not seriously affected there seems to be no damage to the child. Our fetal and infant mortality rates have been greatly decreased since we have lowered our incidence of interference late in pregnancy. I have actually never seen a baby which I thought died as a result of toxemia."

EARLY TERMINATION OF PREGNANCY RECOMMENDED

Although the authors mentioned previously express the conservative attitude, such an opinion is not shared by certain others who present evidence that the fetus does suffer from its toxemic environment. Guerrerio and Plass have stressed the importance of the toxemia itself in the fetal mortality, and have pointed out that the fetal death rate rises as the severity of the disease increases. Cosgrove and Chesley in a paper on the management of the late toxemias of pregnancy support the view that termination of pregnancy after the 34th week is not only in the mother's interest, but might also be true insofar as the fetus is concerned. Perhaps prematurity at this time offers a better outlook for the child than the continuation of pregnancy with the possibility of stillbirth or neonatal death.

Chesley expresses the opinion that until the 34th week of gestation physicians are justified in delaying the interruption of pregnancy in a toxemic patient for the benefit of the fetus, if the life of the mother is not in jeopardy. After the 34th week he considers that there is nothing to be gained by way of improving fetal prognosis, since after that time placental separation or intrauterine death will nullify any gain in maturity. In fact, neonatal fetal prognosis becomes worse after the 34th week.

Today the decision of interruption of pregnancy before the 36th week is somewhat less perplexing than it was a few years ago. The lessened risk from cesarean section and the greater chance of survival of the premature infant suggests that pregnancies with smouldering preeclampsia be interrupted earlier in the hope of getting a live baby, and preventing the onset of eclampsia. In spite of the present relative safety of cesarean section, every effort should be made to induce delivery from below if it can be done without trauma.

When eclampsia occurs near term, labor often takes place spontaneously. Many authorities advise immediate interruption after the convulsive state has subsided because of the threat of recurrence. If induction is not possible, and the fetus is alive, cesarean section is indicated. In Pomerance's series the fatality rate of babies born of toxemic mothers in the gestation period of 37 to 40 weeks was the same as that of babies born between the 34th to 37th weeks. He concluded that from the point of view of the survival of the fetus it would not be necessary to carry pregnancy beyond 34 weeks.

SUMMARY

There is general agreement that from the standpoint of the mother's immediate and ultimate prognosis the sooner a toxemic pregnancy is terminated the better. However as regards fetal prognosis, there is no such general agreement. Since most of the infant deaths in toxemia are due to prematurity, there are some who recommend a waiting policy in the hope that a few more weeks of intrauterine life will give the infant a better chance. On the other hand, there are others who believe that such a waiting policy is ill advised. They express the opinion that the premature infant has a better chance of survival than the fetus allowed to remain in a toxemic environment.

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Prolonged Labor

In the treatment of protracted labor "a careful evaluation of hydration should be made. Adequate rest with heavy sedation is preferred. Excessive analgesics may be avoided if proper prenatal education is instituted to eliminate tension thereby maintaining a natural control of uterine physiology. Intravenous oxytoxin, although hazardous, is definitive therapy for uncomplicated uterine inertia."—Rocco V. Lobraico, Jr., M. D., Chicago: *Illinois M. J.*, 106:182, September, 1954.

Social Factors Affecting the Incidence of Syphilitic Psychosis: a Research Note*

ROBERT M. FRUMKIN and SHELDON R. BAKER

OF the patients entering state mental hospitals as first admissions in Ohio, in the year ended June 30, 1952, less than 3 per cent were diagnosed as syphilitic psychotics. Of those resident in Ohio state hospitals on June 30, 1952, however, 9 per cent were afflicted with this mental illness and had spent a median time length of 9 years and 1 month on the hospital rolls. The median age of first admissions was 47 years; for males, 49 years, and for females, 44 years. For residents with syphilitic psychosis the median age was 55 years.

AIM OF STUDY

To ascertain some of the social factors related to syphilitic psychosis was the main purpose of this study. In order to do this, rates of first admissions to Ohio state mental hospitals were computed for patients with syphilitic psychosis by environment, race, education, occupation, and marital status according to data based on the 1950 census of Ohio.

ENVIRONMENT AND SYPHILITIC PSYCHOSIS

In the case of syphilitic psychosis, as well as other major mental disorders, we find rather definitive differences between urban and rural persons in rates of admission to state mental hospitals. Rates of first admission per 100,000 general Ohio population according to data obtained from the 1950 census, for the year ended December 31, 1949, were as follows:

Environment	Total	Male	Female
Urban	3.5	4.5	2.4
Rural	1.6	2.3	1.0

Thus, rates for urban individuals are approximately twice as high as rates for rural persons.**

RACE AND SYPHILITIC PSYCHOSIS

There are rather pronounced differences in the rates of Whites and Negroes who were first admissions with syphilitic psychosis to Ohio state mental hospitals in the year ended December 31, 1949. The rates for Whites and Negroes per 100,000 general Ohio population, according to data obtained from the 1950 census, were as follows:

Race	Total	Male	Female
White	2.4	3.1	1.7
Negro	13.1	18.0	8.5

*The writers are especially indebted to the Bureau of Research and Statistics of the Ohio Department of Public Welfare for making the data on syphilitic psychotics in Ohio state mental hospitals available for use in this study.

**Data from a recent study of syphilis by the Ohio Department of Health show that, in 1952, metropolitan areas had a rate of 176 syphilitic cases per 100,000 Ohio population; in rural areas the rate was 116.3.

Submitted August 24, 1953.

The Authors

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An examination of the foregoing rates indicates that Negroes have about six times higher rates than Whites. Again, as in the case of alcoholic psychosis, differential rates for Whites and Negroes might be due to the differences in socio-economic status. Since Negroes hold an inferior socio-economic status in our society, and since there seems to be a valid inverse relationship between socio-economic status and rates of mental illness, it becomes clearer why there is such a great disparity in rates of syphilitic psychosis.[1]

EDUCATION AND SYPHILITIC PSYCHOSIS

The extent of an individual's formal education seems also to be related to his chances for being admitted with syphilitic psychosis to a state mental hospital. It was possible to compute rates of first admissions for persons with this mental illness by using the data on the education of persons who were 25 years old and over in Ohio in the 1950 census. Per 100,000 of the general population just described the rates were as follows:

Education	Total	Male	Female
No Education	10.6	15.2	6.2
Elementary	7.9	10.0	5.7
High School	2.2	3.3	1.3
College	1.5	1.9	1.1
Unknown	16.2	19.3	12.5

Examination of the foregoing data reveals that persons with some college education had the lowest rates of admission with syphilitic psychosis. On the other hand, persons with no education or with education unknown had the highest rates of admission. These data suggest that there is an inverse relationship between the extent of an individual's formal education and the probability

that he will be admitted with syphilitic psychosis to a state mental hospital.

OCCUPATION AND SYPHILITIC PSYCHOSIS

The relation of occupation, education, and rates of syphilitic psychosis may be shown directly and indirectly in the rates of first admissions by occupational group. In the following table rates for various occupational groups, by sex, are shown:

TABLE 1. RATES OF FIRST ADMISSIONS WITH SYPHILITIC PSYCHOSIS, BY OCCUPATIONAL GROUP, BY SEX, YEAR ENDED JUNE 30, 1952. (Rates computed on the basis of 100,000 employed Ohio population using 1950 census data.)

Occupational Group	Total	Male	Female
Professional and Semi-professional	0.8	0.6	1.0
Managerial Group	0.0	0.0	0.0
Clerical, Sales, & Kindred Workers	1.1	1.3	1.0
Skilled Workers	2.0	1.8	6.5
Semi-Skilled Workers	1.8	2.2	0.6
Unskilled Workers	10.3	10.2	13.5
Service Workers	6.6	7.4	6.0
Agricultural Workers	2.9	3.1	0.0

It will be noted that persons of professional, semi-professional, and managerial occupations have rates which are about 10 times *less* than rates for unskilled workers. Since the extent of one's formal education and one's occupation are closely related, our data provide further evidence in support of our previously stated hypothesis. We can also see that in the case of the Negro, little education, and low income, low socio-economic status as revealed in occupation, add to his predisposition for syphilitic psychosis and other mental illnesses.

MARITAL STATUS AND SYPHILITIC PSYCHOSIS

Another important factor related to syphilitic psychosis is marital status. Persons who are divorced or widowed have the greatest chances of acquiring this mental illness. This fact is revealed in the following rates per 100,000 Ohio population of persons 14 years old and over, computed on the basis of data obtained from the 1950 census of Ohio:

Marital Status	Total	Male	Female
Single	4.7	3.9	0.9
Married	6.8	4.2	2.6
Divorced or Widowed	23.0	18.6	4.5

Divorced persons are more prone to acquiring syphilitic psychosis than are widowed persons,[2] since widowed persons are exceedingly older and more conservative than younger, unconventional divorced persons.

SUMMARY

We have seen that syphilitic psychosis is related to some of the following social factors: race, socio-economic status as evidenced in occupation, environmental background, education, and marital status.

Negroes have exceedingly higher rates of first admissions with syphilitic psychosis than do Whites because many of them are subject to the factors which seem to increase the risks for acquiring that mental illness. Low socio-economic status as manifested in little education, low income, low prestige occupations, plus family disorganization contribute to the probability of being admitted with syphilitic psychosis to a state mental hospital. Negroes in our society are severely subject to these vitiating factors.

Rural people have lower rates than do urban people. Differential exposure is probably one of the reasons for such differences since the rates of syphilis are much higher in metropolitan areas than in rural areas.

Since this study is concerned with the group or mass phenomena, and is actuarial in character rather than individual, the next step should concern itself with a clinical study of the individual syphilitic psychotic in relation to the primary social factors discussed in this paper. This study is a task for the clinician and is beyond the scope of our inquiry.

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Hemolytic Disease of the Newborn

From the obstetrical point of view, it is of interest to note that, although less than 5 per cent of RH negative women are immunized by pregnancy alone, this figure rises to 50 per cent when there is a history of incompatible RH blood transfusion. The antigen of greatest clinical importance is the D antigen (the original Rh factor). Anti-D alone or in combination with other antibodies is found in the maternal serum in over 98 per cent of cases of hemolytic disease of the newborn.

However, Rh iso-immunization of the mother is not necessarily synonymous with hemolytic disease in the offspring as the maternal antibodies may be due to a previous pregnancy or transfusion and the child may be RH negative and, as such, completely unaffected by the maternal antibodies or the titer of the antibodies may not have reached a level where they can produce the clinical picture of the disease. There is a tendency, nevertheless, for the disease to become progressively more severe in succeeding pregnancies and, where a hydropic infant has been born and the father is known to be homozygous, there is little chance to salvage any future children from this mating.

Unfortunately at the present time, there is no sure means of preventing or even depressing antibody production by the mother.—Marian Waller, M. S., and Albert M. Edmonds, M. D., Richmond: *Virginia M. Monthly*, 81:471, Oct., 1947.

The Thyroid Gland

A Pediatric Review

CARL WEIHL, M. D.

RECENT years have seen remarkable strides made in the diagnosis of thyroid disorders, and an increased understanding of the physiology of the hormonal substance elaborated by the thyroid gland. Ultimately, this must lead to improved methods of treatment, and perhaps prevention, of the metabolic derangements associated with an excess or deficiency of the thyroid hormone.

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THYROXIN VS. TRIIODOTHYRONINE

Until recently, the active component of the thyroid gland has been thought to be thyroxin, a relatively simple chemical compound that can be synthesized by the condensation of two molecules of diiodotyrosine (both *in vivo* and *in vitro)*, which in turn is formed by the double iodinization of the nonessential aminoacid, tyrosine. Thyroxin is stored in the thyroid gland, in combination with a large protein molecule, as thyroglobulin; as the need for hormonal substance occurs, proteolytic enzymatic action converts this to easily diffusable fractions which can enter the blood, where they are joined to other protein molecules to form most of the protein-bound iodine in the plasma.

In the past three years Gross and his group have isolated and identified another iodine containing compound in the plasma of both hyperthyroid and euthyroid persons as triiodothyronine.[1] Both biological and chemical tests have since shown that this substance duplicates the effects of thyroxin in preventing goiter in thiouracil treated animals, in metabolic effects on the various organs of the body, including the pituitary, and in raising oxygen consumption in rats. In addition, experimental evidence indicates that it is several times as effective as thyroxin.

Clinically, triiodothyronine exerts the same effects as thyroxin on hypothyroid patients; the response, though more rapid, is also more evanescent, related, in part, perhaps, to the relatively more rapid disappearance from the blood. At present, it is felt that triiodothyronine may well be the active form of thyroid hormone, and that thyroxin must be converted to the triiodinized compound before becoming physiologically active.

EFFECTS OF HORMONAL EXCESS AND DEFICIENCY

Because of the effect of thyroid substance on cell metabolism and growth and development, the period of childhood is an especially critical one when thyroid hormone is present in abnormally great or small amounts.

The effects of thyroid hormone may conveniently be considered in three categories:[2]

1. **Cell Metabolism**—The basal metabolic rate of body cells is directly related to the level of circulating thyroid hormone; basal cellular metabolism is decreased 60 per cent in the absence of hormone, and is reflected in decreased oxygen consumption, insensible water loss, cardiac output and circulation time. Clinically, this is reflected in a decreased appetite, general inertia, slower peristaltic rate, and bradycardia. Conversely, increase in the amount of circulating hormone leads to increased oxygen consumption, increased insensible weight and water loss, a greater cardiac output and more rapid circulation time; the clinical analogues of the hypermetabolic state are reflected in a larger appetite, emotional and physical lability, increased peristalsis, and tachycardia.

2. **Cell Organization**—The functions of certain body cells become disorganized in the absence of thyroid hormone. Irregular calcification of the developing epiphyseal centers is often noted on x-ray (epiphyseal dysgenesis). The accumulation of an abnormal protein in the extracellular spaces leads to a special kind of edema (myxedema); this is not abolished by raising the metabolic rate, but will disappear when circulating thyroid hormone in adequate amounts is supplied to the tissues.

3. **Growth and Development**—Rates of growth and maturation of body cells are directly related to the amount of circulating thyroid substance. Optimal growth and development occurs in the normal (euthyroid) state; growth rates diminish with decreasing amounts of hormone. Excess thyroid, however, does not cause an acceleration of growth and development, but may actually

result in premature closure of epiphyses and developmental retardation.

RELATIONSHIP TO OTHER GLANDS

Indirectly, thyroid hormone exerts an effect on growth in childhood through alteration in the growth, adrenocorticotropic, and gonadotropic hormones of the anterior pituitary. Clinically, thyroid hormone deficiency results in small stature, signs of adrenocorticotropic deficiency, and a slowing of sex development. On the other hand, hyperthyroidism causes little alteration in growth hormone production, but may interfere with normal gonadotropin production, leading to menstrual aberrations in the adolescent female.

Thyroid-stimulating hormone (TSH), or thyrotropin, is a protein secreted by the anterior pituitary, which controls both the structure and secretory rate of the thyroid gland. In the absence of TSH, the thyroid gland becomes small and ceases to produce thyroid hormone, and hence a secondary hypothyroidism results. There is also a reciprocal relationship between the two glands, so that a decrease in thyroid production leads to a compensatory increase in TSH, and, conversely, an increase in thyroid hormone leads to a decrease in TSH. The ultimate control of this entire regulatory process may lie in the hypothalamic centers affecting anterior pituitary activity.

DIAGNOSTIC METHODS

Clinical Observations: In assessing the status of any hormonal imbalance, it is often possible to make a diagnosis of excess or deficiency of a hormone by a careful clinical appraisal. Certainly, in thyroid disease clinical studies are apt to give clear cut evidence of glandular dysfunction. In the presence of hyper- or hypothyroidism in childhood, clinically apparent changes are usually detectable.

Hypothyroidism (cretinism, myxedema) is accompanied by general inertia (lowered metabolic rate), bradycardia and circulatory impairment (lowered cardiac output and slower circulation time), constipation (decreased intestinal motility), and small stature, with delayed closing of fontanels and late appearance of deciduous teeth (retardation of growth and development). In cretinism both motor and intellectual functions are also moderately to greatly decelerated. Other physical stigmata noted are dry skin, pot belly, umbilical hernia, large tongue, and occasionally myxedema.

On the other hand, hyperthyroidism in childhood is a relatively uncommon disease, and usually has a later onset, between the seventh and thirteenth year. Clinical assessment will usually reveal enlargement of the thyroid gland, tachycardia, increased appetite, sweating, increased tolerance for cold, weight loss, emotional lability, and often exophthalmos. (An exophthalmogenic substance has recently been separated from the pituitary, and seems to be a distinct entity separate from the usual pituitary substance that will produce thyroid hyperplasia).

Laboratory Procedures: To the older, more time-honored methods of assessing thyroid status, several new and challenging techniques have been added. Among the various laboratory procedures available, one or more of the following will usually be of help in determining the level of thyroid activity.[3]

1. Roentgenographic studies are of great value in the determination of thyroid deficiency. Delayed skeletal maturation is usually found in hypothyroidism, and is easily assessed by such techniques as the 67 ossification center survey. X-ray examination also will reveal the presence of epiphyseal dysgenesis, which is due specifically to a deficiency of circulating thyroid hormone.

2. Basal Metabolic Rates are old, proved indices of thyroid activity, and really consist of measurements of total body oxygen consumption under basal conditions (fasting; physical and emotional "rest"). This procedure, with the usual mask and nose clip, is not easily done in children under eight years of age. Because of relatively greater responses of the B. M. R. in childhood to non-thyroid factors, and because of the wide variations in euthyroid subjects, it has limited absolute value in diagnosing hypo- or hyperthyroidism,[4] but may be of value in following the progress from month to month of a patient being treated for thyroid disease.

3. Serum cholesterol determinations are of value only in the assessment of hypothyroidism, where abnormally high levels (above 280 mg. per 100 ml.) are found in about 50 per cent of the patients. A better use of the serum cholesterol level is the observation of a rise in value following the cessation of thyroid therapy (within four months), or a fall from high to normal levels following the institution of thyroid therapy in the hypothyroid child.

4. Uptake of radio-active iodine is a test that requires the use of a Geiger counter, or the newer gamma-detecting scintillation counter.[4] In this test, a small tracer dose of radio-iodine is fed to the patient (radio-iodine is now available commercially, in small capsules requiring no special monitoring); the amount of the iodine taken up in the thyroid gland and the amount excreted in the urine in 24 hours are two fairly reliable measures of thyroid activity.

In the euthyroid patient, 30 per cent of the ingested radio-iodine appears in the thyroid in 24 hours; about 65 per cent will be excreted in the urine. In the hypothyroid patient, from zero to 10 per cent will appear over the gland; 70 to 90 per cent will appear in the urine. The hyperthyroid patient will trap up to 70 per cent in the gland, and excrete only about 20 per cent.

5. Plasma protein-bound iodine determina-

tions correlate well with the radio-iodine tracer test, but are relatively more difficult to perform. The protein-bound iodine level, a measure of circulating thyroid hormone, varies from 4 to 8 micrograms per 100 cc.; slightly higher values (to 12 micrograms per 100 cc.) are found in the first few weeks of life. In athyrotic individuals the value seldom exceeds three micrograms.

6. Thyrotropin assays are of value in attempting to discover whether the clinical status of a patient with thyroid dysfunction is due to a primary disorder of the thyroid or secondary to an abnormality of pituitary TSH (thyroid stimulating hormone or thyrotropin) secretion.

Bioassay by injection of the patient's serum into a tadpole and observing the effect on the thyroid of the tadpole is one approach. Another one, recently illustrated by Pickering and Miller,[5] involves the determination I^{131} uptake before and after an injection of TSH. Absence of uptake before, and normal uptake after injection of TSH indicates that the hypothyroidism is secondary to lowered TSH secretion by the pituitary. A failure of response does not necessarily prove the presence of primary hypothyroidism, since prolonged absence of TSH may result in an atrophic thyroid gland no longer capable of responding to an injection of TSH.

MANAGEMENT

Hypothyroidism in childhood should be treated as early as possible with the daily administration of 60 to 90 mg. of USP thyroid per square meter of body surface irrespective of age or size.[2] Because of the danger of too precipitate an increase in body metabolism in infants, the initial therapy should be one-quarter of the recommended dosage; after two weeks, this may be increased to one-half, and after four weeks to three-quarters, if all goes well. At the end of six weeks the full daily therapeutic dose may then be given. The maintenance dose should eliminate metabolic signs of hypothyroidism, but not be pushed to the point of toxicity.

Hyperthyroidism may be managed with a number of agents, including iodide salts, radio-iodine, and thiouracil and related drugs. In addition, subtotal thyroidectomy is utilized to treat selected severe cases of thyrotoxicosis.

The choice of which agent or procedure to use is not an easy one, and there is still considerable difference of opinion as to the most appropriate procedure. In many cases, the disease runs a cyclic, self-limited course, and needs no therapy. This cyclic fluctuation in severity must be considered in evaluating the results of any type of therapy in thyrotoxicosis in childhood.

In mild to moderate cases, iodide salts are given daily (0.3 cc., or 5 minims, of saturated potassium iodide solution) for six to twelve months after all symptoms of hyperthroidism have disappeared. Thiouracil drugs may be given to the more severe cases, and at present propylthiouracil (120 to 175 mg. per square meter of body surface per day, divided into three doses, given every eight hours) is the drug of choice. Because of the undesirable side-effects of this group of drugs, and because of the necessity of long continued therapy, a subtotal thyroidectomy in the hands of a capable surgeon is often a more satisfactory procedure for both the patient and his family.

The prolonged course of thiouracil therapy, frequent visits to the doctor, frequent blood counts, and the slower abatement of symptoms poses for the child, and particularly for the adolescent, many of the emotional problems faced by the post-rheumatic fever patient on a prolonged course of sulfonamide prophylaxis; hence, a fairly radical subtotal thyroidectomy may, in many instances of moderate to severe thyrotoxicosis, be the treatment of choice. Blattner, on the other hand, feels that during adolescence treatment with a relatively nontoxic drug such as propylthiouracil is preferable to surgical intervention,[6] although the decision is often a difficult one for even an experienced, unbiased clinician to make.

The use of radio-iodine to destroy thyroid cells by internal radiation has been used with success in adults, but because of the chance of degenerative changes that might end in malignancy years later, it is not at present recommended for use in juvenile cases of thyrotoxicosis.[2]

PROGNOSIS

As previously indicated, juvenile patients with thyrotoxicosis may be handled as adequately as adults with both medical and surgical techniques, with a hopeful and usually successful outcome.

On the other hand, hypothyroidism in childhood, even with adequate therapy, has a much poorer outlook than myxedema in the adult. The ultimate skeletal length of the treated hypothyroid is usually within normal limits; this is more apt to be so if the patient is also mentally competent, and also if therapy is instituted early in life, or shortly after signs of hypothyroidism appear. The ultimate intelligence of the cretin is much more apt to be depressed; if the disease is present at birth (congenital cretinism) or before the age of two years, only one-quarter of the patients will have an I. Q. above 80. Should the disease appear after two years of age (acquired cretinism), 90 per cent of the patients will have I. Q.'s above 80. Whether the early institution of therapy in the congenital cretin will materially alter the ultimate outlook is still undecided, but every

effort should be made to institute therapy early, continuously and in adequate amounts.

GOITER

In addition to the glandular enlargements associated with hypothyroidism or hyperthyroidism discussed previously, certain cases of thyroid enlargement (goiter) occur in childhood without evidence of glandular hyper- or hypofunction.

Neonatal goiter, present at birth, usually causes symptoms related to pressure on adjacent structures (trachea, great vessels in the neck, laryngeal nerves). Within a few days after birth the gland starts to shrink, and the symptoms disappear. Symptomatic therapy will usually tide the infant over this period.

Endemic goiter usually occurs in infants born of mothers with goiters arising from iodine deficiency, and is usually seen in iodine-poor areas. Hypothyroidism often, but not always, accompanies this type of goiter.

Adolescent goiter is the commonest swelling of the thyroid gland seen in childhood. There is a soft, uniform, symmetric swelling of the gland, and the only symptoms which occur are usually related to the size and pressure of the gland. Treatment with iodine is effective, but most endocrinologists at present prefer to use U. S. P. thyroid (60 to 120 mg. per square meter of body surface daily for 12 to 18 months); therapy should be instituted early if complete involution is to be accomplished.

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Antibiotic-Cortisone Therapy In Infectious Asthma

Combined antibiotic-cortisone therapy seems rational in infectious asthma because such treatment combats two outstanding causes of the disease, bronchial infection and bronchial inflammation. . . .

It is concluded that antibiotics and cortisone should be utilized not only to relieve and rehabilitate advanced cases of asthma with irreversible pulmonary pathology but even more as an early causal therapy to prevent a common and costly chronic disease.—Walter Finke, M. D., Rochester, N. Y.: *New York State J. M.*, 54:2685, October, 1954.

KEEPING UP WITH MEDICINE

• It is to be noted that although man, the dog, the cat, and the rat show similar effects after the removal of the pancreas, the goat, the pig, the rabbit, and the duck appear to show only slight disturbances.

* * *

• Two biochemical blocks are evident in the diabetic state: (1) the conversion of the two-carbon units into higher fatty acids and (2) the conversion of glucose into fructose-6-phosphate.

* * *

• Insulin appears to release the inhibitory effects of diabetic tissues on hexokinase activity.

* * *

• It is well known that epinephrine exerts a strong glycogenolytic effect in animal tissues. This effect is exerted both on muscle and liver tissue whereas the pancreatic hormone other than insulin, a hyperglycemic-glycogenolytic factor (the HG factor), is limited in its action to the liver system only.

* * *

• Leg ulcers are prone to occur in the diabetic because the resistance to infection of the sugar-laden tissues is reduced and because the arteries are the subject of endarteritis and the nerves of peripheral neuritis.

* * *

• Insulin coma, whether the result of overdosage or of hypersecretion of a tumor of the islets of Langerhans, is marked by collapse, low blood pressure, sweating, and low blood sugar.

It is to be remembered that there are a score and more causes of the hypoglycemic syndromes. In *functional hyperinsulinism*, the liver function is normal. The attacks are not progressive in severity. They occur more frequently under emotional or physical stress, and usually two to four hours after eating. The fasting blood sugar is normal on a regular or low carbohydrate diet. The glucose tolerance test shows little or no hyperglycemia and there is a sharp fall to hypoglycemic levels between the second and fourth hour.

In *organic hyperinsulinism*, the fasting blood sugar is usually below 50 milligrams per hundred cubic centimeters. On testing, the glucose rises but little in the first two hours and goes to very low levels after the second hour.

* * *

• In hepatogenic hypoglycemia, the liver function is impaired; attacks are progressive, more apt to occur at night or when a meal is skipped. The fasting blood sugar is low. The oral glucose tolerance test shows a marked initial hyperglycemia with glycosuria followed by a fall to hypoglycemic levels in the course of four to seven hours.—J. F.

Proceedings of the Ohio Society of Pathologists

Reported by PAUL N. JOLLY, M. D., Cincinnati, Ohio

THE fall meeting of the Ohio Society of Pathologists was held at the department of pathology, Cincinnati General Hospital on Saturday, September 19, 1953. The meeting was well attended by members of the society from all parts of the state with a good representation from Kentucky and Indiana.

SCIENTIFIC PROGRAM

The scientific portion of the meeting was opened with a paper titled, "Spontaneous Gastric Perforation in the Newborn," by Dr. Herbert Braunstein. Five cases were presented, two from the autopsy files of the Cincinnati General Hospital of the preceding five years, two observed personally by Dr. Braunstein, and one case treated surgically.

The condition is seen in the neonatal period with major symptoms similar to those seen in acute gastric dilatation, including respiratory distress, cyanosis, abdominal distention, and vomiting. Roentgenograms in either the erect or lateral decubitus position reveal free air in the peritoneal cavity. The perforation usually occurs in the cardia and is surrounded by a zone in which the gastric wall is attenuated. Sections through such areas reveal a progressive diminution in the gastric muscularis which is normal at one extreme and aplastic at the other. The mucosa and the muscularis mucosae remain intact up to the edge of the perforation.

Two cases studied extensively revealed numerous lesions throughout the stomach with hypoplasia or aplasia of the gastric musculature demonstrable histologically. Such areas showed no grossly detectable deviations from normal.

USE OF CHELATING AGENT IN HISTOCHEMICAL STUDY OF ENZYME ACTIVATION

The second paper was presented by Dr. David C. Freiman and was titled, "The Use of a Chelating Agent in the Histochemical Study of Enzyme Activation." A chelating agent is a chemical compound which has the ability to combine with ionized materials and bind them into an inactive compound. Many chelating agents are more familiar as water softeners or as ion exchange resins.

The activation of many enzyme systems has as one of its essentials the presence of a specific metallic ion. It has been previously demonstrated that removal of these ions will inhibit the activity of specific enzymes. In the study reported, EDTA (ethylenediaminetetraäcetic acid) was used to remove the metallic ions from alkaline phosphatase within tissue sections.

Submitted August 18, 1954.

A series of photomicrographs was presented showing the locations of the alkaline phosphatase in the proximal tubules of the rabbit kidney. Subsequent slides demonstrated how the enzyme could be deactivated by the use of EDTA and how the enzyme activity could again be restored by the use of appropriate metallic ions. Other metallic ions, such as manganese, cadmium or lead produce no effect on the intact enzyme but fail to produce reactivation after chelation with EDTA. A third category of metallic ions including mercury, beryllium, copper and ferric iron not only failed to reactivate the chelated enzyme, but also destroyed the activity of the intact enzyme system.

The ability of EDTA to combine with calcium also makes it an excellent agent for decalcification of bone without causing the cytologic distortion caused by the low *p*H in conventional methods. Applicability of this agent in the study of alkaline phosphatase in bone was demonstrated.

Sections through the costochondral junction showed that the greatest activity of alkaline phosphatase occurs along the zone of provisional calcification and around the trabeculae of the cancellous bone, where the osteoblasts are located.

LIVER LESIONS FOLLOWING USE OF PLASMA SUBSTITUTE

The third paper, "Liver Lesions Following the Intravenous Administration of Polyvinylpyrrolidone (PVP)," was presented by Dr. Edward A. Gall. His observations were part of a study being conducted at the Cincinnati General Hospital on the use of this plasma substitute.

Reports from Germany, where PVP was first used, are contradictory as to the presence or absence of liver lesions following the use of the substance. In the present study, a number of chronically ill individuals, who could be kept under observation for a long period of time, were selected for study. The livers were essentially normal on the basis of clinical studies and a needle biopsy. Following a single intravenous infusion of 1 liter of 3 or 4 per cent PVP in normal saline, liver function studies and repeat needle biopsies of the liver were performed up to a maximum of 15 months after the infusion.

Tissue taken previous to the fourth or fifth month showed no significant abnormalities. After this time, small inclusions stained pale blue with the H and E technic appeared in the Kupffer cells. Histochemical studies revealed that these inclusions contained no polysaccharide, protein,

or lipid. The material, however, did stain intensely with both Lugol's iodine and with Congo red. *In vitro* tests with the PVP showed identical staining reactions and it was thought that the inclusions in the Kupffer cells of the liver were either PVP or were closely allied to it.

It was also concluded that the deposition of this material attained considerable bulk (50 to 100 micra), but that there was a lag of approximately two months before it appeared in tissues. Individuals followed-up to 15 months following the infusion have shown no decrease in the quantity of the deposits. In the latter months, occasional mild lymphocytic and fibrocystic infiltration is seen in the tissue around some of these deposits.

VALIDITY OF GRADING COLONIC CARCINOMA

The fourth paper, "Histologic Grading of Colon Carcinoma—A Valid Procedure?," was presented by Dr. Robert Qualheim. Since introduced and first popularized by Dr. Broders, the grading of malignant tumors has been widely used both as an index of malignancy of these tumors and frequently as a guide to therapy. Recent studies at Cincinnati General Hospital on gastric carcinomas and on bronchogenic carcinomas have raised considerable doubt as to the validity of this procedure in these two lesions.

Thirty cases of resected colonic or rectal carcinoma were used in this study. After removal of a small portion of tissue for histologic diagnosis, the specimen was flattened, pinned on cardboard, and fixed in formalin. Following fixation, large blocks were taken through the entire tumor mass and the adjacent mucosa, and large tissue sections prepared. These large tissue sections then were examined, first under the dissecting microscope, where zones of variation were marked, and then were studied in greater detail under higher magnifications. Of the 30 cases studied only eight, or approximately 27 per cent, showed a uniform grade of tumor through all of the areas sectioned. These generally corresponded to approximately a grade II tumor. The other 22 lesions showed considerable variation of the histologic pattern with occasional tumors showing lesions characteristic of grade I through grade IV. Several specimens also included additional portions of tumor of the colloid carcinoma type.

BUSINESS MEETING

Following the scientific program there was a brief business meeting, opened by the president, Dr. Goodsitt of Cleveland. Dr. Goodsitt reported that the Executive Committee had discussed the problem of shortage of technicians endemic to many areas of the state and appointed a committee to be headed by Dr. Philip Wasserman to meet with a similar committee of the Ohio Society of Medical Technologists to formulate a recruitment program for student technicians. Dr. Horace Davidson reported that a meeting would be held in Columbus on September 27, 1953, to discuss the problem of testing of accredited diagnostic laboratories. This meeting is to be attended by Dr. Goodsitt and Dr. Davidson as representatives of this group.

* * *

ABSTRACTS OF CASES FROM SLIDE SEMINAR

Moderator: Dr. Edward A. Gall
Cincinnati, Ohio

History abstracts and slides were sent to all members for study prior to the meeting. The final diagnoses represent the majority opinion of the Society.

Case 487. Presented by Dr. Robert J. Ritterhoff, St. Elizabeth's Hospital, Covington, Kentucky.

Microscopically the epithelium was thickened with hyperkeratosis and acanthosis. Throughout the spinous layer were small and large nests of rather large foamy or vacuolated cells with pleomorphic, hyperchromatic, nuclei showing numerous mitotic figures. Occasionally these cells penetrated the stratum granulosum to reach the stratum corneum.

Final diagnosis: *Extra-mammary Paget's disease.*

Case 488. Presented by Dr. Robert J. Ritterhoff.

The lesions were seen over the lower legs and were characterized by thickened, crusted, hyperpigmented epithelium elevated above the surrounding normal appearing skin. Several of these were rather indurated, while smaller ones were soft and fluctuant. Microscopically the deeper portions of the corium were markedly thickened and edematous.

Final diagnosis: *Pretibial myxedema.*

Case 489. Presented by Dr. Paul N. Jolly, Christ Hospital, Cincinnati, Ohio.

Microscopically the lesion was characterized by numerous crystalline deposits separated by fibrous trabeculae of varying size, which were infiltrated with moderate numbers of large phagocytes and foreign body type giant cells.

Final diagnosis: *Gouty tophus.*

Case 490. Presented by Dr. Benjamin Landing, Children's Hospital, Cincinnati, Ohio.

Sections revealed that the predominate cell was a large macrophage with an occasional Touton type giant cell. In addition there were large numbers of eosinophiles and occasional neutrophiles.

Final diagnosis: *Eosinophilic granuloma.*

Case 491. Presented by Dr. Daniel Richfield, Booth Memorial Hospital, Covington, Kentucky.

The major portion of the specimen consisted of essentially normal appearing thyroid gland, small foci of which showed minimal evidence of hyperactivity. The adjacent bone around the

tumor showed some erosion and occasional spicules were necrotic.

Final diagnosis: *Adenocarcinoma (thyroid), metastatic to bone.*

Case 492. Presented by Dr. Paul Wozencraft, Cincinnati General Hospital, Cincinnati, Ohio.

Microscopically the tumor was quite cellular and composed of elongated or polyhedral cells. These were frequently arranged in a radiating fashion around small cystic spaces or around capillaries. In more solid portions, the cells were frequently arranged in irregular festoons. The cells were of uniform size. Nuclear abnormalities were not noted.

Final diagnosis: *Ependymoma.*

Case 493. Presented by Dr. William Collins, Good Samaritan Hospital, Cincinnati, Ohio.

The tumor was a spindle-shaped mass with recognizable optic nerve at one pole. Over one surface was a zone of reactive thickening of the nerve sheath with dilated blood and lymphatic vessels surrounded by an increased quantity of fibrous tissue. The tumor itself was made up of irregular nests of glial cells in which could be identified astrocytes, oligodendroglia, and microglia.

Final diagnosis: *Glioma of optic nerve.*

Case 494. Presented by Dr. William Collins.

Microscopically the lungs showed diffuse calcification involving predominately the alveolar septa, but occasionally the walls of the blood vessels.

Final diagnosis: *Metastatic calcification of the lungs.*

Case 495. Presented by Dr. Benjamin Landing.

Microscopically the collecting tubules were filled with crystalline spicules and plates, which were doubly refractile. Occasionally erosion of the tubular epithelium was seen with mild reaction in the adjacent stroma.

Final diagnosis: *Urate nephrosis.*

Case 496. Presented by Dr. Herbert Braunstein, Cincinnati General Hospital, Cincinnati, Ohio.

The sections of the stomach showed a zone in which the normal gastric musculature became progressively hypoplastic and finally absent. The muscularis mucosae and the mucosa were intact.

Final diagnosis: *Congenital defect of gastric musculature.*

Case 497. Presented by Dr. Robert Carson, Holzer Hospital, Gallipolis, Ohio.

Although the lesion appeared rather sharply defined in the gross, microscopic sections revealed that the peripheral borders of the mass were rather poorly defined from the adjacent normal appearing liver. The tumor mass was characterized by small and large nodules of liver cells. Many appeared normal and others were swollen and occasionally vacuolated. The lobular architecture was completely lost, and large fibrous septa were scattered through the mass. Within these fibrous septa were large numbers of bile ducts and varying amounts of lymphocytes.

Final diagnosis: *Postnecrotic liver nodule.*

The Story Behind the Word

Some Interesting Origins of Medical Terms

Hemophilia or Haemophilia—We owe this term to Johann Lucas Schönlein, a German physician who in 1828 applied the term to all cases of the hemorrhagic diathesis. This familial disease which is characterized by a delayed blood clotting time and which frequently results in uncontrollable hemorrhage was known to the ancients. The old Hebrews knew of hemophilia since the Talmud forbade the circumcision of boys of those families in which the death of two successive sons had followed this rite. The disease was also described by Albucasis in the 10th century, but was not established as a separate disease entity until 1823 by John Conrad Otto, a Philadelphia physician. Hemophilia is composed of the Greek word for blood, which is "haima," plus the Greek "philos," or love.

Scopolamine—This alkaloid is so named because it is obtained from the dried rhizome or roots of the plant Scopoli Carniolica. This herb was named in honor of the 18th Century Italian naturalist, Giovanni Antonio Scopoli.

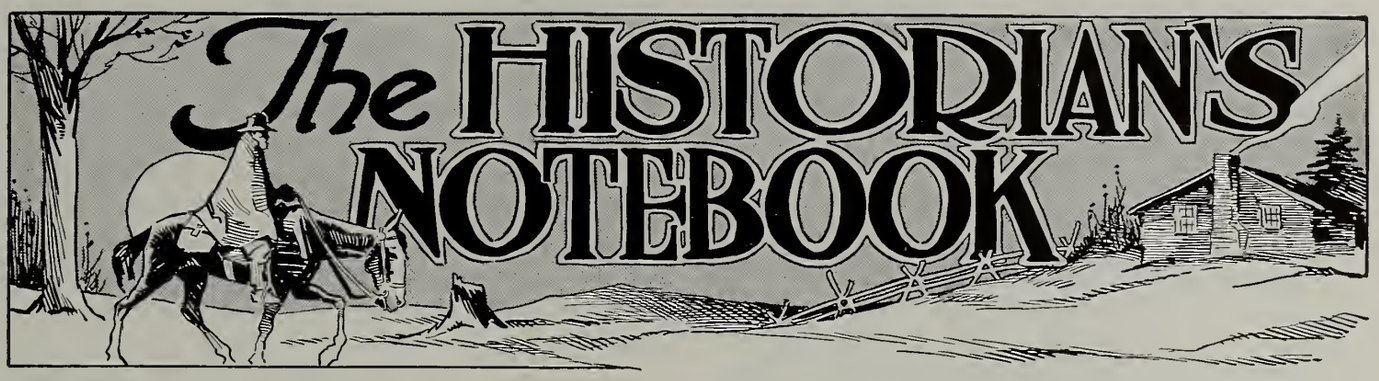
Soda—This old name for the oxide of sodium came into English via the French word "soude." This word possibly stems from the Latin word "solida," or solid, however the Romans did not use the term soda, but mistakenly called this substance nitron. It is more probable that our word "soda" comes from the Arabic word "suda" meaning headache, because soda was the chief remedy used for headaches by the ancient Arabians.

Strangury—A term denoting painful urination whereby the urine is voided drop by drop. The term is descriptively derived from the Greek words "stragx," or drop, plus "ouron," or urine.

Ectropion—This condition was recognized by the ancients. In about 550, A. D., Aetius defined ectropion as a condition in which the lower eyelid is everted. It is a simple descriptive term which is composed of the Greek "ek," or out, and "trope," a turning.

Element—It is said that the early Roman alphabet began with the letter *L*, hence when the Romans learned the alphabet, they learned their *L. M. N.'s.* From this we get the Latin word "elementum" meaning the first principle. The ancients applied this term to mean basically the simplest form of matter and for a long time it was believed that there were only four elements, earth, water, air, and fire. In 1678 Robert Boyle the English chemist used this term in chemistry to denote a simple substance from which compounds are formed. In 1789 Lavoiser further defined the term "element" giving it its modern meaning.

—Harry Wain, M. D., Mansfield, Ohio.



History of the Montgomery County Medical Society 1849-1949

PART II

CURTISS GINN, M. D.

(Concluded from October issue)

1889-1909

THIS was the period of the "Gay Nineties," of nostalgic memory, a time when the city was not too large to know almost everyone met on the street, few taxes, and a dollar was still worth one hundred cents. The time of bell-shaped "toppers," flaring skirted Prince Albert coats and striped trousers, worn by a few of the members of the profession daily and by the others on Sundays. Dr. George Goodhue was elected president in 1900, and for most of the decade largely controlled the destinies of the society. Friction developed between the older members and the younger element; as a result, The Dayton Academy of Medicine was formed with its membership consisting of the malcontents. Membership fell in the older body to a low level. A banquet was held but despite much oratory, many exhortations and good resolutions, the attendance remained poor. Five years later, the attendance was only 35 on the average.

LIBRARY BEGUN

In 1892, Dr. D. W. Green, an O. & O. specialist, the only one in this field in the city, interested himself in the formation of a medical library for the use of members; a committee was formed and in '95, it was announced that a thousand volumes had been purchased and housed in the public library. It was at this time that minutes of the first meetings were found after having been lost since the Civil War. They were placed with the library for safe keeping.

It is interesting to read of one of the members being brought before the censors, for using the newly discovered "Diphtheria Antitoxin," or rather the fact that in some way a notice of the same had found its way into the daily paper. The yellowed clipping is still pasted in the minutes and seems not too bombastic compared with some publicized items of later date.

The high point of this decade was the passage of the Medical Registration Act, the first effective effort to control or regulate the practice of medicine within the State (1896). This society worked hard for its passage. Although not perfect, it required that the holder of a diploma from any medical college should present it to the Probate Judge of the various counties, a permanent serial number to be stamped upon it, and this was to be referred to in all official documents and communications. The law had this equity in its administration, in that any physician who had been in practice for a ten-year period preceding the passage of the act was to be allowed to continue, providing he was of good moral character after a very simple examination.

While the city had had a Board of Health for a number of years, it had degenerated into an ineffective body; it was reorganized under a competent medical man.

The society, likewise took its stand with the

The Author

● Dr. Ginn, now retired after many years of surgical practice in Dayton, has devoted a considerable amount of time to research in the historical background of medicine in Dayton and Montgomery County.

State, in requiring a high school diploma as a prerequisite for admittance to medical colleges. At this time, too, the having of out-of-the-city speakers at the meetings was inaugurated. Also, plans for the establishing of a Tuberculosis Society were formulated.

A man who was destined to play a large role in the future activities of the profession, Dr. L. G. Bowers, came during this decade—1905. Without the benefit of too much formal schooling, he was a man of much native intelligence, an incessant worker, and a keen politician; it was not long before his impact was felt. He became president of the local society twice and the State Society once.

1909-1919

During this period, the lid of Pandora's box flew open and released a host of disasters, which remain to plague humanity to this day. Of these, the greatest locally, was the Dayton flood of March, 1913. A minor loss was the disappearance of the society minutes from 1910 to 1914. Since all records of the period are missing, an effort has been made to reconstruct the salient points at least, through the memories of the remaining doctors, who lived through the time.

On the heels of the disaster, the U. S. Health Service promptly appeared on the scene and took charge of affairs. In view of the danger of epidemics of various sorts from interruption of the water and sanitation services, the overcrowding of the peoples displaced, a thorough survey of conditions was ordered. Private practice was forgotten and all the doctors worked long hours without recompense. Each morning the weary men reported to their stations and took up the task of examining and reporting on the sanitary conditions found, the presence of water connections, and sanitary sewer installations. The final tabulation showed that some 40 per cent of the houses had no sewer connection, and 35 per cent relied upon shallow wells for their drinking water. Thanks to the vigilance of the Board of Health and the able assistance of members of the medical profession, the epidemics did not appear.

INDUSTRIAL COMPENSATION

A State Industrial Compensation law, passed in 1913, though a long needed measure for the care of industrial injuries, met with much opposition from the local doctors. They feared it might be the forerunner of State medicine, objected to the low fees established, and the red tape paper work connected.

On the death of Dr. W. J. Conklin in 1916, a bronze tablet commemorating his services to the city and the profession was ordered erected, but owing to the push of events, there is no sign that it was ever carried out.

The outbreak in Europe, of what was to end in World War I, found the profession as well as the nation, thanks to our political leaders, less concerned about events abroad than how to combat the depression of the past two years. The rumblings of war did not become too ominous until late 1916, so that when the United States entered the conflict in the spring of 1917, it came as an unwelcomed shock. The universal draft law was passed and within a few months, 22 per cent of the local doctors were in the military service.

The conflict over on November 11, 1918, the various services for the most part disbanded, returning members came filtering back, together with many new faces—medical men who had been dislocated by the war and now sought new and possibly more remunerative fields. The specialists, who heretofore could almost have been counted on the fingers of one hand also came; pediatricians, neurologists, orthopedists, obstetricians, surgeons, dermatologists and pathologists.

FIDELITY BUILDING

In 1919, The Fidelity Building and Loan Association erected an office building designed as a medical building, and largely, if not entirely, due to the efforts of Dr. L. G. Bowers, space was provided in the new building as quarters for the county society, the first permanent home it had ever had. Besides room for offices and an auditorium there was room to move the medical library from the public one. Dr. H. S. Jewitt, whose activities have been recorded earlier in this history took over the office of librarian. A medical bibliophile himself, he spent long hours cataloguing, indexing, and cross-indexing the collection—purely a labor of love, as the $60.00 per month salary was a mere pittance compared with the time and labor expended. He continued this office until 1926, when his health would no longer permit.

1919-1929

With the increased number of medical men in the city and the depression of 1921 curtailing payment of medical fees, the question of the free hospital clinics, that had been the custom for years, came in for severe criticism. It was felt that many people were availing themselves of these facilities, who should not make use of the services intended for the indigent. Moreover, the clinics themselves had become unwieldy and were of considerable expense to the city. A decision was reached, declaring that an income of over $60.00 per family would render an applicant ineligible for free service. In 1925, the Homeopathic Society—some 25 members—was invited to amalgamate with the Montgomery County Society, providing the sectarian name was dropped.

In 1927, the first full time combined secretary and librarian was employed. Also this year a

movement on the part of the city officials to abolish the offices of school physicians and nurses was successfully opposed.

In 1929, members of the Homeopathic fraternity, with a few exceptions, were accepted as members of the society. In view of the poor attendance at meetings, an average of 40 members, a programme of advertising through the newspaper columns and the radio was tried without much success. The publicity was directed to the public; it might have been better directed toward the members themselves.

The end of the decade was marked by the death of Dr. H. S. Jewett, the last of the three musketeers, who had such a large hand in directing the activities of the society some years earlier.

1929-1939

The annual meeting of the American Society for the study of goiter marked the first time that a gathering of more than State scope had been held in Dayton. It also saw the disastrous crash of the stock market of October 29, 1929, and with this went a deal of the doctors' investment values. A medical clinic under the leadership of Dr. Bowers was perfected and moved into quarters on Wyoming Street. It, however, was short-lived, passing out of existence in '35.

The depression began in 1929, deepened until it reached its lowest point in midsummer of '35. Unemployment and financial distress became universal, and this included the medical profession. The Federal Government attempted to solve or at least alleviate the condition by means of the W. P. A., the P. W. A., and a host of other alphabetical agencies. Some payment to the doctors for the treatment of persons on relief was made though the fees were small and the red tape and paper work connected were quite annoying.

ABOLITION OF FREE CLINICS

Under the conditions present, the free hospital clinics were abolished with one exception, the venereal department, which the county placed in a downtown location. All of the rest were turned over to the United States relief agencies. Since the city's finances were also in desperate straits, script was issued by it to be used in the payment of bills locally for necessities, including medical attention; this script was supposed to be redeemable at some future date.

Three past presidents passed to their reward during the first two years, Drs. Goodhue, Grey, and Ewing.

In 1935, the various relief agencies set up for the care and payment of medical treatment were abolished, and the burning question was how to care for the people thus turned adrift. Group hospitalization plans for the ones needing hospitalization were provided but care for the ambulant and home cases remained for the doctors for whatever fees the patients could or would pay or in promises for the future. In '36, the forerunner of the present monthly medical society bulletin and a Medical Service Bureau was begun. The 20 per cent discount on all State Industrial and medical bills in force since the beginning of the depression was lifted. A special section of the O. & O. specialists having been in operation for a few years and proving a success, the society authorized sections for all other specialties when requested.

In 1937, the State Society held its Annual Meeting in Dayton under the presidency of Dr. Bowers. During this and the following two years, the society lost by death a number of its older members, among them being Drs. Peters, Hewett, Otto, and L. G. Bowers. An official seal for the society was adopted and gold keys issued to all of the living past presidents.

1939-1949

Largely under the auspices of Dr. E. M. Huston, the society erected a bronze plaque at the entrance to the Centerville village, dedicated to Dr. Jonathan Hole, the first physician to locate in this territory in 1788. The cemetery trustees have given the title to the grave site to the Montgomery County Medical Society. Dr. C. D. Smith, who through the years had been a faithful attendant at the meetings and at one time president, died in 1940.

In spite of the Administration's assurances that this country would not be drawn into the European wars, the society deemed the possibility great enough to formulate a medical preparedness program as a contingency. A part in the "Bundles for Britain" was assumed. Though the regular schedule of meetings was kept up, the interest of the members was centered on political matters rather than medical ones. With the attack on Pearl Harbor, December 7, 1941, and the immediate declaration of war by the United States, all local interests receded into the background. Within a few weeks, 21 members were in uniform and before the conflict was ended, over 40 per cent of the others were likewise attired; so many, in fact, that a request was sent to the authorities requesting that no more men be taken from this district as the number of physicians left was insufficient to care for the population, hampered by the rationing of tires and gasoline as they were, and the influx of war workers.

THE HOME FRONT

Despite all the handicaps, time was found to assist in the work of the Tuberculosis Association. Much overtime work was put in by the remaining members on the various boards accessory to the Services, and to the screening of draftees not alone from this county but adjoining ones also.

In 1943, the office of full-time recording secretary and librarian was abolished and a temporary

secretary appointed from the membership. 1945 saw the end of the fighting and rapid demobilization of most of the men in unfiorm and a return of the absent members. A fund which had been contemplated for the use of the returnees was found to be of little use as the crying need was for office and living space. In 1946, in order to take some of the burdens off of the various officers, a full-time lay secretary was employed, whose duties included attendance at meetings of the various political, civic, and private organizations and act as a liaison officer. Mr. Robert Freeman was chosen.

As after World War I, the medical profession was on the move. New men flowed into the area, 49 new members being admitted to the society in 1946 alone. Though the tempo has decreased, the numbers are still considerable. The earlier monthly bulletin assumed a new dress with an increased number of pages. A committee of the past-presidents was formed, including the president and the president-elect, to plan for the future of the society and prepare details for the coming centennary in 1949.

With four new sections formed and approved—surgical, medical veterans, neuropsychiatry and one for the general practitioners, the list would seem to be complete, at least for the time being. A roster of the membership in this year showed 440, an average of one physician to approximately 960 people. Quite a difference from the 200 of a century ago.

Many problems will face Medicine in the coming century. Medicine classed as a profession for hundreds of years is facing a change. Owing to the advances in knowledge and the various aids to diagnosis and treatment in transforming it into a business, the art of practicing is being lost. With the small number of doctors in proportion to the population as a whole, the world-wide trend toward socialism, at least, and the rapid and large increase in the cost of hospital and doctors bills, it is not improbable nor even unlikely, that some measure of regulation and limitations will be applied to the medical class; that these will be unwelcomed goes without saying.

Looking back on the century just passing, it should be a matter of pride and congratulation that this particular society with its own particular problems has matched up so well with the other branches of society.

What the coming century will bring is in the "Lap of the Gods," but let us hope that whatever befalls, it will be met with the same fortitude that our forebearers displayed.

The troubled conditions of the past ten years have been so disruptive and the perspective has been too short to try to assess the measures passed and the men at the head of affairs, as has been possible in the earlier years. Time alone will evaluate the acts and actors. Sufficient to say, that each has done his duty as he saw it and met the various emergencies to the best of his ability.

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LIST OF PRESIDENTS OF THE MONTGOMERY COUNTY MEDICAL SOCIETY (1849-1949)

1849 Edwin Smith
1850 Michael Garst
1851 Henry VanTuyle
1852 Julius Taylor
1853 John Davis
1854 Job Haines
1855 Job Haines
1856 I. A. Coons
1857 W. C. McDermont
1858 W. H. Lamme
1859 S. G. Armour
1860 W. C. McDermont
1861 J. C. Reeve
1862 J. C. Reeve—No meetings after July, '62, until October, '65.
1866 R. Gundry
1867 John Davis
1868 W. C. McDermont
1869 R. Gundry
1870 R. Gundry
1871 R. Gundry
1872 R. Gundry
1873 J. C. Reeve
1874 Thomas Neal
1875 Thomas Neal
1876 John Davis
1877 J. C. Reeve
1879 J. M. Weaver
1880 Thomas Neal
1881 Thomas Neal — Dr. W. C. McDermont finished this term.
1882 J. S. Beck
1883 J. S. Beck
1884 W. J. Conklin
1885 W. J. Conklin
1886 H. S. Jewett
1887 C. H. Humphries
1888 E. C. Crum
1889 Patton — Surgeon at Soldiers Home
1890 George Goodhue
1891 J. M. Weaver
1892 G. C. Myers
1893 Horace Bonner
1894 G. B. Evans
1895 R. C. Pettit
1896 D. C. Lichleiter
1897 D. W. Green
1898 D. C. Huffman—Surgeon at Soldiers Home
1899 W. J. Conklin
1900 W. J. Conklin
1901 J. S. Beck
1902 J. S. Beck
1903 J. C. Reeve, Jr.
1904 J. C. Reeve, Jr.
1905 F. C. Grey
1906 F. C. Grey
1907 C. W. King
1908 W. S. Smith
1909 E. M. Huston
1910 Records Lost
1911 H. C. Haning
1912 R. C. Pennewit
1913 Records Lost
1914 Records Lost
1915 Records Lost
1916 Records Lost
1917 Records Lost
1918 E. A. Baber—Superintendent State Hospital
1919 E. A. Baber—Superintendent State Hospital
1920 L. G. Bowers
1921 L. G. Bowers
1922 E. A. Mallow
1923 A. F. Shepard
1924 C. N. Christman
1925 A. O. Peters
1926 A. B. Brower
1927 P. H. Kilburn
1928 H. V. Dutrow
1929 C. H. Tait
1930 W. B. Bryant
1931 H. H. Herman
1932 F. K. Kislig
1933 A. F. Kuhl
1934 C. D. Smith
1935 A. F. Farmer
1936 H. F. Koppe
1937 R. S. Binkley
1938 E. L. Braunlin
1939 S. H. Dickinson
1940 M. D. Prugh
1941 W. A. Ricketts
1942 E. M. Smith
1943 R. K. Findley
1944 C. D. Padan
1945 C. J. Derby
1946 N. E. Leyda
1947 A. D. Cook
1948 N. Hockwalt
1949 E. R. Arn

The Stark County Story as Told In Radio Broadcasts

Industry Comes of Age—1901-1917, The Stark County (Ohio) Story, Volume III, by Edward Thornton Heald. ($10.00. *The Stark County Historical Society, Box 483, Canton, Ohio).* This book is Stark County's contribution to the Ohio Sesquicentennial Celebration, observed in 1953. There is a considerable amount of information about physicians and their relation to the community and to the industrial development of the area.

Proceedings of The Council . . .

Heavy Docket Considered at Granville Sessions; Plans and Schedule of Events for 1955 Annual Meeting Approved; Reports of Committees Heard

THE regular Fall meeting of The Council of the Ohio State Medical Association was held at the Granville Inn, Granville, Ohio, September 18 and 19, 1954. All members of The Council attended. Also in attendance were Doctors A. A. Brindley, Toledo, Carl A. Lincke, Carrollton, C. C. Sherburne, Columbus, and William M. Skipp, Youngstown, delegates to the A. M. A.; Dr. Jonathan Forman, Editor of *The Journal*; Dr. Carl A. Wilzbach, Cincinnati, chairman of the Committee on Education; Dr. H. P. Worstell, Columbus, chairman of the Committee on Industrial Health and Workmen's Compensation; Dr. Frank H. Mayfield, Cincinnati, chairman of the Committee on Legislation; Dr. E. K. Yantes, Wilmington, chairman of the Committee on Rural Health; Dr. Ray M. Turner, Springfield, chairman of the Committee on Veterans Affairs; Mr. Wayne Stichter, Toledo, legal counsel; and Messrs. Nelson, Saville, Page and Moore of the headquarters office.

LETTERS OF APPRECIATION

After several general announcements Dr. Prugh advised The Council of receipt of a letter from Mr. C. F. Kettering, expressing appreciation for a telegram sent to him by the Association at the time of his recent birthday anniversary. Letters of appreciation also were received from Dr. Robert Conard and Dr. J. H. J. Upham for the recognition given to them during the annual banquet at the time of the 1954 Annual Meeting. A communication from Mrs. Elizabeth August, who recently retired as executive secretary of the Ohio State Nurses' Association, was read, in which she thanked the Association for the fine cooperation given to her during her many years of service with that organization. Also read was a letter from Dr. Charles L. Hudson, Cleveland, Councilor of the Fifth District, expressing appreciation for the communications of sympathy sent to him at the time of the death of his mother.

On motion duly made, seconded and carried, the minutes of the meeting of The Council held on May 23, 1954, were **approved.**

MEMBERSHIP FIGURES

The Executive Secretary presented statistics on the membership of the Association and membership of Ohio physicians in the American Medical Association. He reported that as of September 15, 1954, the total membership of the State Association was 8,150, consisting of 7,779 dues-paying members; 176 members whose dues are waived because of military service, and 195 members whose dues are waived because of retirement due to age or disability. The total number of members as of December 31, 1953, was 8,068.

The data showed that as of September 15, 1954, 7,171 Ohio physicians were members of the American Medical Association. The total consisted of 6,596 dues-paying members; 172 members whose dues are waived because of military services and 403 whose dues are waived because of retirement due to age or disability. The total A. M. A. members from Ohio as of December 31, 1953, was 6,941.

A breakdown of these figures by counties and districts was distributed to members of The Council.

TUSCARAWAS COUNTY AMENDMENTS

Amendments to the constitution and by-laws of the Tuscarawas County Medical Society, adopted by that society on June 10, 1954, were read to The Council and, on motion duly made, seconded and carried, were **approved.**

UNION COUNTY AMENDMENTS

A letter from the Union County Medical Society, stating that a resolution had been adopted by that society approving certain amendments to the constitution and by-laws of that society, was read and discussed. Action was **deferred** by The Council, inasmuch as the text of the amendments had not been submitted for review by The Council. The Executive Secretary was instructed to confer with the officers of that society and assist them in getting the amendments into proper shape for action by that society.

MEMBERSHIP FOR INTERNS AND RESIDENTS

The Council considered a communication from the American Medical Association, pointing out that the House of Delegates of the A. M. A. at the 1954 annual session had adopted a resolution urging state and local societies to establish a type of membership for physicians in internship or residency training. The communication pointed out that many such physicians were unable to meet the regular dues and that some of them were unable to meet a requirement that a member must hold a license in the state in which he is taking his internship or residency.

On motion made, seconded and carried, this question was referred to the Executive Secretary and to Mr. Stichter with instructions to draft proposed amendments to the Constitution and

By-Laws of the Ohio State Medical Association, establishing membership for interns and residents and to submit such proposals to The Council at its December meeting. It was pointed out that final action on this matter would have to be taken by the House of Delegates.

REQUEST FROM PRACTICAL NURSES

A request from the Practical Nurses Association of Ohio, that the Ohio State Medical Association make a financial contribution to a program of extension courses for practical nurses, was discussed. **On motion made, seconded and carried,** the question was referred to the Committee on Auditing and Appropriations for study and for a report to The Council at its December meeting.

1955 ANNUAL MEETING

The next item of business was consideration of a detailed report from the Committee on Scientific Work with respect to plans for the 1955 Annual Meeting to be held in Cincinnati the week of April 17. In the absence of Dr. Ernstene due to illness, the Executive Secretary presented the following report which, **on motion made, seconded and carried, was approved by The Council:**

A meeting of the Committee on Scientific Work of the Ohio State Medical Association was held in the Columbus office on Sunday, September 12, 1954. Those present were: Dr. A. Carlton Ernstene, Cleveland, chairman; Dr. Thomas E. Rardin, Columbus; Dr. Robert M. Zollinger, Columbus; Dr. M. D. Prugh, Dayton, President; Dr. D. W. Heusinkveld, Cincinnati, President-Elect; Dr. Jonathan Forman, Columbus, Editor of *The Journal*; and Messrs. Nelson, Saville, Page and Moore of the headquarters office staff.

The committee reviewed thoroughly the minutes of a committee meeting held on August 29, at which representatives of various specialty societies were present.

The following actions, taken by the committee on August 29, were confirmed and ordered submitted to The Council for consideration:

There was a general discussion with respect to the 1954 meeting in Columbus. The program was given critical analysis and it was agreed that in general the program was good. It was felt, however, that the Columbus arrangements were not satisfactory and that the meeting should not be brought back to Columbus until Columbus is able to offer more adequate centralized facilities.

There was general agreement that the idea of setting aside the better part of one day for meetings of the specialty societies should be continued. By action of the committee, this was put into the form of a formal recommendation for Council consideration.

Nervous and Mental Section

The committee considered a request from the Ohio Psychiatric Association that the Section on Nervous and Mental Diseases be reactivated. By official action, the committee voted to recommend to The Council that the section be reactivated and that The Council consider naming as officers of the section Dr. Calvin L. Baker, Columbus, chairman, and Dr. William E. Todd, Columbus, secretary, the president and secretary, respectively of the Ohio Psychiatric Association.

Abstracts

The committee felt that perhaps the printing of brief abstracts on the talks to be made by the various speakers in the official program might attract larger attendance at the various sessions. The Executive Secretary pointed out that we now ask speakers for abstracts and that this procedure would be stepped up in an effort to secure suitable material for publication in the program in connection with the announcements of topics and speakers.

Exhibit by Anesthesiologists

During the discussion some members pointed out that one of the serious problems is that of cardiac arrest in surgical cases. It was recommended that the Ohio Society of Anesthesiologists be requested to put on an exhibit at the 1955 Annual Meeting emphasizing the causes and prevention of cardiac arrest and that the exhibit be manned with someone competent to discuss this with those visiting the exhibit.

Centralized Registration

Representatives of the specialty societies were in agreement that some plan of centralized registration should be worked out if at all possible. It was felt that the regular badge of the Association would be satisfactory. It was felt that in some instances it might be necessary to have someone from the registration staff of the State Association present at places where the specialty societies are meeting in order to register those who fail to present themselves to the general registration headquarters of the State Association at the Netherland Plaza.

Scientific Programs Open To All

It was agreed by all that the scientific programs of the specialty societies would be open to all members of the Ohio State Medical Association and that the only limitation of attendance to members of those societies would be at the business meetings of such societies, if any.

Sale of Tickets

Representatives of the specialty societies indicated that they would like very much to have a plan worked out whereby tickets for luncheons or dinners sponsored by such societies could be sold at the general registration headquarters of the State Association at the Netherland Plaza.

Section Fund

The committee was advised by Dr. Ralph H. Miller, Cincinnati, the 1954 chairman of the Section on Ophthalmology, that he is maintaining a bank account for the old Section on Eye, Ear, Nose and Throat and that the account now has a balance of $256.81. Dr. Miller pointed out that this money had to be transferred from secretary to secretary year after year and that he felt the money should be turned over to the Ohio State Medical Association. In discussing the matter the committee voted to recommend to The Council that it advise Dr. Miller that the Association would accept the fund, if the section authorized, and that the money would be used to help finance the purchase of certain projection apparatus for use of the staff of the Columbus office, or which equipment could be lent to county or district societies on request.

A number of matters agreed upon tentatively

at the August 29 meeting were reconsidered. Based on additional discussion and study, the committee took the following actions and ordered them submitted to The Council for consideration and action:

Schedule of Events

A schedule of events for the 1955 meeting was drafted for Council action. (See schedule on Page 1065.)

Guest Speakers

The committee felt that it would not be feasible to have thirteen guest speakers, which would be the number in event each section were to be allowed a guest speaker. Therefore, it was agreed that part of the sections would be permitted a guest speaker for 1955 and the remaining sections would be permitted a guest speaker in 1956. In other words, a rotating system of guest speakers was agreed upon.

The following sections were selected as entitled to guest speakers in 1955, if the section wants a guest speaker:

Otorhinolaryngology
Anesthesiology
Internal Medicine
Neurosurgery
Obstetrics and Gynecology
Pediatrics

The following sections were **not assigned** guest speakers in 1955 but would be entitled to a guest speaker in 1956:

Surgery
General Practice
Nervous and Mental Diseases
Ophthalmology
Radiology
Urology
Physical Medicine

It was felt that the above rotating system would enable the committee to formulate a better balanced program for the general sessions.

Selection of Guest Speakers

It was decided that the guest speakers would be selected by the Committee on Scientific Work on recommendation of the appropriate section officers. The section officers will be requested to submit the names of three possible guest speakers in the order of preference. The responsibility for contacting the nominees will be that of the chairman of the Committee on Scientific Work. It was felt that this procedure would eliminate some confusion and embarrassment in the extending of invitations.

Scientific Exhibit

On recommendation of Dr. Heusinkveld and Dr. Herrmann, Dr. Bruce G. McMillan, Cincinnati, was designated as chairman of the Committee on Scientific and Educational Exhibits.

It was the belief of the committee that more awards should be given for scientific exhibits. The plan used by the American Medical Association was thoroughly reviewed. The following recommendations were adopted by the committee:

1. That gold, silver and bronze certificates be awarded for exhibits deemed outstanding from the standpoint of original investigation.
2. That gold, silver and bronze certificates be awarded for exhibits deemed outstanding for teaching purposes.
3. That special certificates be awarded for unusual exhibits not falling within the above categories.
4. That the new plan for awards be publicized and promoted.
5. That The Council select the committee to judge the exhibits and that members of the judging committee not necessarily be confined to the membership of The Council.

Viewboxes

Material from the A. M. A. regarding transparency cases was studied. It was decided that the material describing the transparency cases be sent out to all past scientific exhibitors, to medical centers and to hospitals. The purpose of this would be to give pertinent information to men preparing exhibits and to those who have exhibits and contemplate the use of transparency cases.

Specialty Society Programs

It was decided that all specialty societies planning to hold meetings on Wednesday should be requested to submit detailed material on their programs to the Columbus office well in advance so that this could be printed in the program.

Dr. Howard as Guest

It was suggested that Dr. E. B. Howard, Assistant Secretary and General Manager of the A. M. A., be invited to be luncheon speaker at the Annual County Society Officers Conference.

Conference With Section Officers

The committee held a joint meeting with the officers of the various sections.

The general program setup was reviewed and agreed to.

Representatives of the Section on Obstetrics and Gynecology and Section on Urology stated they planned a combined meeting of the two sections.

The question of having a recess to tour exhibits in the middle of the programs was discussed. Some felt that this interrupted the programs. The reason for the recess was explained. The committee decided to take the matter under reconsideration and to work out recesses which would not be inconvenient to the sections if at all possible.

It was agreed that December 1 should be the deadline for presentation of program material by the Section Officers.

It was agreed that suggestions on guest speakers would be submitted immediately to Dr. Ernstene, chairman of the committee.

The following section representatives attended the conference:

Section on Anesthesiology—Dr. J. J. Jacoby, Columbus, Chairman, and Dr. Lloyd E. Larrick, Cincinnati, Secretary.

Section on General Practice of Medicine—Dr. J. H. Shanklin, Springfield, Chairman, and Dr. Floyd A. McCammon, Van Wert, Secretary. Dr. Earl D. McCallister, Columbus, Secretary of the Ohio Academy of General Practice, also attended.

Section on Internal Medicine—Dr. Maurice A. Schnitker, Toledo, Chairman, and Dr. H. Campbell Haynie, Columbus, Secretary.

Section on Neurological Surgery—Dr. Harry LeFever, Columbus, Chairman, and Dr. Laurence M. Weinberger, Akron, Secretary.

Section on Obstetrics and Gynecology—Dr. Dean E. Sheldon, Sandusky, Chairman, and Dr. Zeph J. R. Hollenbeck, Columbus, Secretary.

Section on Ophthalmology—Dr. Claude S. Perry, Columbus, Chairman.

Section on Otorhinolaryngology—Dr. Edward

W. Harris, Columbus, Chairman, and Dr. Paul M. Moore, Cleveland, Secretary.

Section on Pediatrics—Dr. O. W. Hosterman, Columbus, Chairman, and Dr. George F. Patterson, Cincinnati, Secretary.

Section on Physical Medicine—Dr. Herman J. Bearzy, Dayton, Chairman, and Dr. Harry Zankel, Cleveland, Secretary.

Section on Radiology—Dr. L. J. Gibboney, Cincinnati, Chairman, and Dr. George A. Nicol, Dayton, Secretary.

Section on Surgery—Dr. Vinton E. Siler, Cincinnati, Chairman, and Dr. Stanley O. Hoerr, Cleveland, Secretary.

Section on Urology—Dr. William J. Engel, Cleveland, Chairman, and Dr. Edward F. Ockuly, Toledo, Secretary.

HOSPITAL ACCREDITATION

Dr. Woodhouse, chairman of the Committee on Hospital Relations, reported on some recent developments on the accreditation of hospitals. He reported that three members of the committee and representatives of the Columbus office had attended the workshop on accreditation of hospitals in Columbus on July 15-16, sponsored by the Ohio Hospital Association. The Council requested the Executive Secretary to send to members of The Council the individual reports of those attending the workshop.

Dr. Woodhouse stated that he felt the National Commission on Accreditation of Hospitals was taking a more practical point of view in the investigation and accrediting of hospitals in Ohio; that some of the problems confronting certain hospitals were being alleviated; and that indications were that the accreditation program would work more smoothly in the future.

Dr. Woodhouse stated that his committee was still prepared to assist individual hospitals in meeting any problems which arise and that the committee would continue with its work of securing information on the situation in Ohio.

RURAL HEALTH

Dr. Yantes and Mr. Page reported on activities of the Committee on Rural Health. Dr. Yantes presented and discussed the following minutes of the meeting of the Committee on Rural Health held on August 25:

Those present were: Dr. Merrill D. Prugh, President of the Ohio State Medical Association; Dr. Edmond K. Yantes, Chairman of the Committee on Rural Health; and the following members of the committee: Drs. Jonathan Forman, Worthington; Carl F. Goll, Steubenville; L. W. High, Millersburg; H. R. Mayberry, Bryan; G. N. Spears, Ironton; and Kenneth Taylor, Pickerington. Also present were: Charles S. Nelson, Executive Secretary; George H. Saville, Director of Public Relations; and Hart F. Page, Committee Secretary.

Lecture Series Expanded

Dr. Yantes discussed the "Lecture Series on General Practice in A Small Community," which has been conducted by the committee during 1952, 1953 and 1954 for the senior medical students at the Ohio State University.

It was announced that a similar series will be established at the University of Cincinnati College of Medicine late in 1954 by the committee with the cooperation of the local chapter of the Student American Medical Association. The committee recommended to Council that this project and its extension continue to have the support of the Ohio State Medical Association.

Scholarship

The Ohio State Medical Association Rural Medical Scholarship program, in effect since 1949, was reviewed and the status of the recipients was reported to the committee. On motion by Taylor, seconded by Spears, the committee recommended to Council that the program be continued. On motion by Goll, seconded by Mayberry, the committee requested Council to give serious consideration to increasing the scholarship program to two awards each year.

Dr. Mayberry reported on the Second Annual Conference for Residents, Interns and Senior Medical Students at Detroit, sponsored by the Michigan State Medical Society. It was decided that this type of program was not adaptable to the committee's present program. On motion by Spears, seconded by Taylor, the committee thanked Dr. Mayberry for attending the meeting and for his report.

Rural Health Council

The activities and purposes of the Ohio Rural Health Council were then discussed. On a motion by High, seconded by Spears, the committee recommended to Council that the Association continue to lend active and financial support to the Ohio Rural Health Council.

The committee reviewed suggested copy for a proposed booklet for distribution to county medical society rural health committees. The copy was approved subject to minor amendments and resubmission to the members of the committee by mail.

Legislation

Mr. Nelson reviewed the developments in public health since the last meeting of the committee. He discussed the Wheeler Bill; the financing of the State Health Department; and recent personnel changes in the latter organization.

Mr. Page related that the brucellosis campaign was still active and that an estimated one-quarter of a million copies of the committee's publication "Mr. Farmer! Protect Your Family" have been distributed. Nationwide effects of the educational campaign begun in Ohio by the committee and cooperating organizations were discussed by the committee.

Health Education

Mr. Page reported that since the previous meeting of the committee the problem of when and when not to use rabies vaccine in the treatment of animal bite had arisen. He related that a chart providing assistance to the physician in making this decision had been prepared by the Chief of the Division of Communicable Diseases of the Ohio Department of Health and mailed with the OSMAgram to all members of the Ohio State Medical Association. The committee suggested that the material be published in The Ohio State Medical Journal.

Dr. Mayberry brought up the problem of inadequate revaccination against smallpox. On a motion by Mayberry, seconded by Taylor, the

committee voted to recommend to Council that the Ohio State Medical Association confer with the State Department of Health with regard to an educational campaign for more effective immunization programs against certain communicable diseases, especially among adults.

Conference with Farm Groups

At 6:30 P. M. the members of the committee were hosts at a dinner meeting with the following farm organization representatives: Mrs. Litta K. Roberson, Home and Community Director, Ohio Farm Bureau Federation; Morris Alton, Director of Public Affairs, Ohio Farm Bureau Federation; R. Bruce Tom, Lecturer and Chairman of the Health Committee, Ohio State Grange; Wilbur B. Wood, Director, Ohio Agricultural Extension Service; H. W. Harshfield, State 4-H Club Leader; and Guy Dowdy, Secretary, Ohio Rural Health Council. Sewall O. Milliken, Chief, Division of Health Education, Ohio Department of Health, was also present.

Dr. Yantes opened the joint meeting with a description of the Committee's program during the six years since it previously met with the farm organization representatives. He asked for an evaluation of the committee's activities and for suggestions for improvements and future projects.

Comments from the farm leaders indicated a general approval of the committee's program and appreciation of the committee's willingness to work with the other organizations in finding solutions to problems of rural health, both statewide and local.

Suggestions Made

Suggestions from the guests included: programs to encourage farm families to choose a family physician; more cooperation among physicians and farm people on the local scene; use of physicians as speakers on health matters on Grange and Farm Bureau programs; physician help with the health education aspects of the 4-H Club health program.

Director Wood revealed Agricultural Extension Service efforts to reestablish the position of Extension Specialist in Rural Health Organization, vacant since the resignation of Mr. Milliken.

It was suggested that a booklet summarizing the health projects of the various organizations which comprise the Ohio Rural Health Council be published.

ACTIONS BY COUNCIL

The Council discussed the report of the committee, item by item. It **approved** the recommendation that the committee continue to present lectures on general practice in rural and small communities to senior medical students in Ohio.

It **referred to the Committee on Auditing and Appropriations** the committee's suggestion that two scholarships be granted annually.

It **approved** the recommendation of the committee that the Association continue active support, including financial support, to the Ohio Rural Health Council.

It **referred to the Committee on Education** the matter of an educational program for more effective immunization among adults against certain communicable diseases.

The report of the committee as a whole, with the exceptions noted above, was **approved** and the committee congratulated on the fine job which it has been and is doing.

PRE-ELECTION ACTIVITIES

Dr. Mayfield presented a report on the activities of the Committee on Legislation. His remarks were supplemented by reports by Mr. Nelson and Mr. Saville. Reports were submitted on the district pre-election conferences held to date and members of The Council were urged to encourage their respective county societies to do follow-up work between now and the election on November 2.

Dr. Prugh stated that Mr. James A. Rhodes, Republican candidate for governor, had requested a conference with representatives of the Association. The Council authorized Dr. Prugh to select a committee to confer with Mr. Rhodes.

In accepting the report of the committee, The Council congratulated the committee on its activities and on the success of the district conferences.

PUBLIC RELATIONS COMMITTEE

The Executive Secretary, on behalf of the Committee on Public Relations and Economics and in the absence of Dr. Wright, chairman of that committee, reported on business transacted at a meeting of the committee held on August 22.

JOINT COMMISSION IDEA REJECTED

The Committee on Public Relations reported that it had discussed a request from the American Medical Association that there be organized in Ohio a Joint Commission for the Improvement of the Care of the Patient, similar to a commission now functioning on a national basis. The commission would be composed of representatives of the medical profession, hospital association, nurses association and league for nursing.

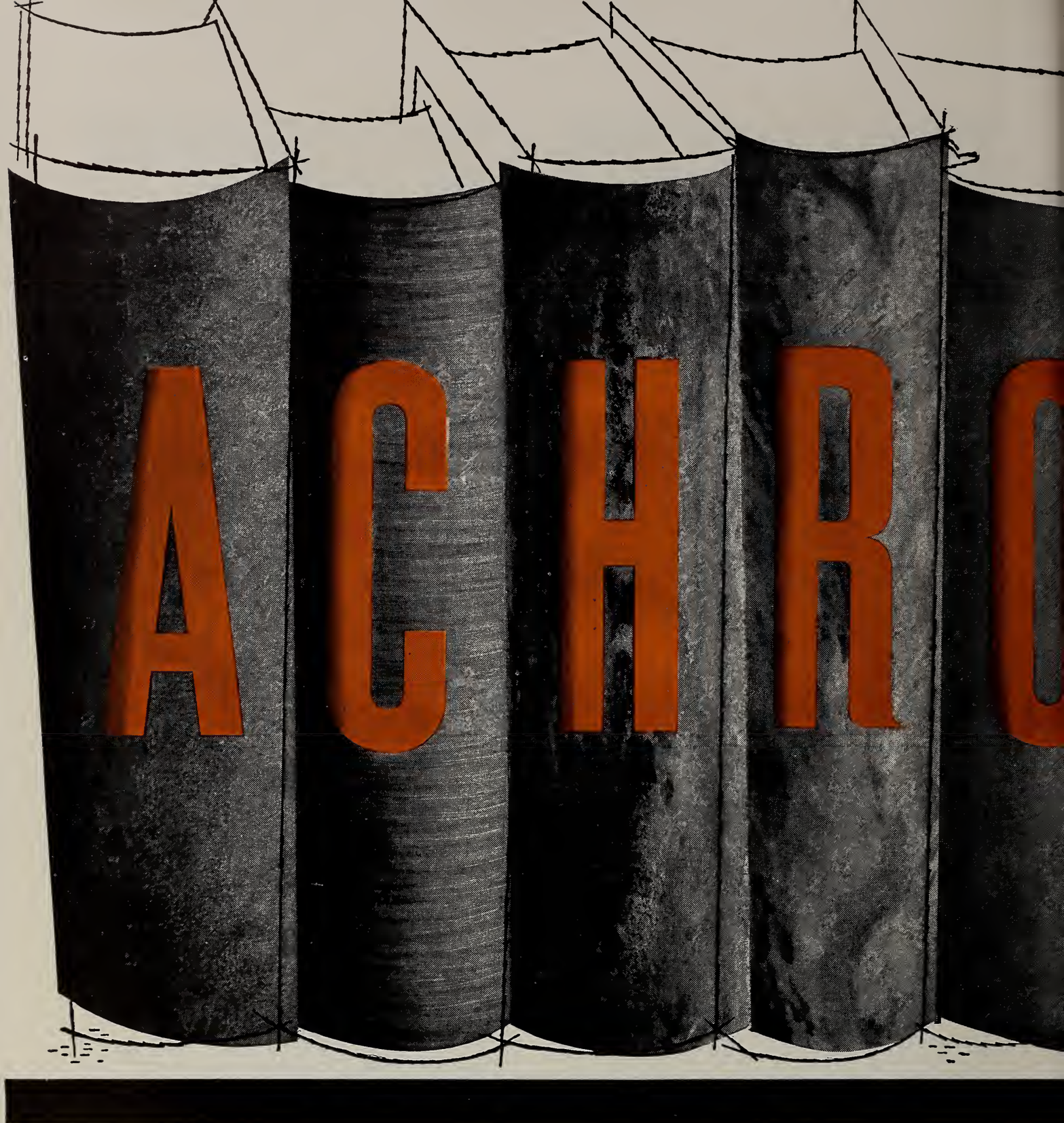
After a thorough discussion the committee decided not to endorse the organization of such a commission in Ohio. It was pointed out that under the present policy of the Ohio State Medical Association the Association has been able to deal successfully with other organizations on questions of mutual interest through various committees and special conferences and that a formal organization such as proposed would not be necessary.

On motion made, seconded and carried, The Council **approved** the action and recommendation of the committee on this matter.

ACTION ON PROFESSIONAL PROBLEM

The committee reported that it had studied carefully a letter from a member raising a question as to who should or should not be admitted as a spectator in hospital operating rooms and

(Continued on page 1062)



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where the authority to make rules governing this rests.

The committee reported that by unanimous vote the committee took the following action:

1. It is the opinion of the committee that the staff of a hospital or governing board of the hospital, is within its rights to make reasonable rules and regulations as to who shall or shall not be permitted to witness operations performed by members of the staff.

2. If a member of the staff believes that such rules and regulations are unreasonable or discriminatory, he should present the matter to his County Medical Society for discussion and action, inasmuch as matters of this kind are primarily local in scope.

On motion duly made, seconded and carried, the action of the committee on this question was **approved.**

BILLS CONSIDERED

The committee reported that it had considered a number of proposals which may be submitted to the next Ohio General Assembly for action and would report to The Council later on them.

Certain miscellaneous actions taken by the committee were **approved** by The Council.

VETERANS AFFAIRS

Dr. Prugh announced the appointment of the following as members of the newly created Committee on Veterans Affairs and his appointments were approved by The Council by official action: Dr. Ray M. Turner, Springfield, chairman; Dr. F. P. Berlin, Lima; Dr. Max T. Schnitker, Toledo; Dr. John H. Budd, Cleveland; Dr. S. W. Ondash, Youngstown; Dr. Carl F. Goll, Steubenville; Dr. W. B. Faircloth, Zanesville; Dr. Chester H. Allen, Portsmouth; Dr. Robert C. Kirk, Columbus; Dr. C. J. Cranston, Wakeman; Dr. Richard L. Meiling, Columbus; Dr. Robert S. Green, Cincinnati; Dr. A. A. Brindley, Toledo; Dr. Herbert B. Wright, Cleveland; and Dr. Paul Troup, Dayton.

Dr. Prugh then presented Dr. Turner, chairman of the new committee. Dr. Turner said that he planned to get the committee together in the very near future in order to lay out a program of activity.

Members of The Council requested the Executive Secretary to have them placed on the mailing list of the new Federal Medical Services Newsletter being issued by the Council on Medical Service, A. M. A.

WORKMEN'S COMPENSATION

The Executive Secretary made a verbal report on a conference held with Mr. Richard W. Morse, chairman of the Ohio Industrial Commission and Mr. M. C. McAuliff of the Actuarial Department of the Commission regarding the proposed increases in the Medical and Surgical Fee Schedule submitted to the Commission a year ago by the Association. Comments were made also by Dr. H. P. Worstell, Columbus, chairman of the Committee on Industrial Health and Workmen's Compensation.

The following letter from Mr. Morse, dated August 11, 1954, on this question was read and discussed:

"It is my understanding that your group will hold its regular meeting September 17, 18, 19, and it was my hope that we could meet with you before that time to consider the new fee schedule.

"Our staff has been unable to complete the study we are making of the entire medical cost problem. However, I am sure that the study will be well along by October 1. May I suggest that you fix a date for sometime about the middle of October that will be convenient for your committee to meet with us."

By official action, The Council instructed the Executive Secretary to advise Mr. Morse that a committee from the Association was anxious to meet with the Commission at the earliest possible date.

COMPLAINTS AGAINST PHYSICIANS

Complaints filed against several physicians were reviewed and referred to individual members of The Council for follow-up action with the local medical societies involved or left pending for review at a later date.

HYPNOSIS DEMONSTRATION

A communication from Dr. Jay Jacoby, Director of Anesthesia, Ohio State University Medical Center, asking for the opinion of The Council as to the propriety of offering a demonstration on hypnosis in a training program for residents in anesthesiology, was discussed. **By official action,** The Council expressed itself as seeing no objection to such a demonstration as a part of the teaching program of the medical center.

MILITARY ADVISORY COMMITTEE

A report on the activities of the Military Advisory Committee was submitted by the Executive Secretary on behalf of Dr. Drew L. Davies, chairman of the committee, who was unable to be present at the meeting. The report consisted of analyses of activities of the committee since the first of the year and a review of articles which have been printed from time to time in *The Journal.* It read as follows:

(1) Information Release No. 16, Subject: "Reclassification of II-A Registrants."

It is stated in this Release that the groups most urgently needed to meet the future calls are those registrants in Priority I and II and the Priority III's born after August 30, 1922, who are finishing their internships by the first of July. All the hospitals were notified not to appoint any physicians in the above groups for further training.

Selective Service was also informed through this Release to have all these men tabbed up-to-date as to their classifications.

(2) Information Release No. 18, amending

Operations Bulletin No. 88, subject: "Selective Service Operations Bulletin No. 88 regarding: Classification of persons who are both regular and special registrants."

It is stated in this release that a regular registrant who is also a special registrant has a dual liability for service, and that all local boards should continue to give serious consideration to the deferment of a regular registrant or special registrant who holds a degree in either medicine or dentistry in order that he may complete one year of internship and that such a registrant would be placed in II-A classification until he has completed this internship. It was also stated again in this Release that the hospitals should not appoint any Priority I, II or Priority III's born after August 30, 1922.

A survey of hospital staffs taken during the hospital year ending June 30, 1954, indicated there were approximately 1,300 interns and more than 1,000 residents who are in Priority III and under 32 years of age and that this number will be required to fill the indicated needs of the Armed Forces during the year ending June 30, 1955.

(3) A. M. A. Washington Letter No. 86, Page 2.

ARMY TAKING 100 PHYSICIANS, FIRST IN 16 MONTHS: Defense Department has asked Selective Service to call up 550 physicians under the doctor draft for assignments in December. 100 are scheduled to go to the Army, the first since August, 1953. Defense said the Air Force requires 200 and the Navy 250. The Defense Department also requested 150 dentists, all for the Air Force.

(4) December Call.

Ohio Selective Service indicates there will be a Call for December 10th which will be as follows:

For 25 physicians (1 was a Priority I . . . 3 were Priority II's and the remaining 21 are Priority III's.) This leaves just a few remaining Priority I and II's who are still in a II-A deferred classification.

For 5 dentists (This call takes all the remaining Priority I and II Dentists.)

The 25 physicians and the 5 dentists are to be allocated to all three branches of service.

(5) The Local Boards are continuing regularly the requests for recommendations of all registrants who are vulnerable for military service so that their classifications will be up to date at all times.

All registrants who are in II-A classification, their cases are re-opened and considered anew at the end of their deferments.

The situation that has presented the biggest problem is that the hospitals even though they were notified not to appoint any physician in Priority I or II or any in Priority III born after August 30, 1922, for further training, many did so anyhow.

All of the other states are of course advised to keep all their registrants classified the same as we are, therefore we are receiving constantly requests from out of state chairmen about their men who are either in hospital work or practicing in Ohio.

(6) Each year at this time the Office of Defense Mobilization in Washington sends out Form ODMF-101 to all of the hospitals. The forms are completed and the yellow copy is sent to the Advisory Chairman of the State. This form enables us to obtain a clear picture of the situation in each hospital as to how many interns, residents, how many aliens, their hospital specialty service, date of birth, etc. This is of great value in considering the case of a registrant who is employed by one of the hospitals.

The report of the committee was accepted and the committee thanked for its excellent work.

Dr. Meiling stated that the policy adopted at the Ohio State University College of Medicine has been not to ask for deferment for any resident but to employ residents even though they may be vulnerable for military service and to provide that they would be eligible for resumption of their residency after completing their tour of active duty. Members of The Council suggested that the Military Advisory Committee issue a statement to all hospitals providing residency training, recommending that they follow a procedure similar to the one at the Ohio State University Medical Center.

COMMITTEE'S NAME CHANGED

By official action, The Council changed the name of the Committee on National Emergency Medical Service to the Committee on National Defense to make the title of the committee conform to the change made in the name of a similar agency of the American Medical Association.

INSURANCE ADVERTISING CONTRACT CANCELLED

Several complaints regarding the sales activities of, and the coverage offered by, the United Insurance Company, which at the present time is advertising in *The Ohio State Medical Journal*, were considered. By official action, The Council instructed the business manager of *The Journal* to discontinue publication of such advertising and to advise the State Journal Advertising Bureau, Chicago, of this action.

DELEGATES REPORT

The delegates from Ohio to the American Medical Association reported verbally on the June meeting of the A. M. A. House of Delegates in San Francisco. Their reports were supplemented by remarks and comments by Dr. Prugh who attended the meeting.

A. M. E. F. PROGRAM

Dr. William M. Skipp, Chairman of the American Medical Education Foundation Committee in Ohio, and Mr. Saville announced plans for the Fall campaign to obtain contributions for the A. M. E. F. from Ohio physicians. It was reported that a letter will be sent to all members of the Association in October soliciting their support, and that a chairman had been appointed in each of the 88 county medical societies to do the follow-up on the campaign locally.

Results of the 1953 campaign were reviewed. In 1953, a total of 542 Ohio physicians contributed $25,958 to the American Medical Foundation and 2,089 donated $103,066.67 directly to the Alumni Funds of their own medical schools. Since the establishment of the A. M. E. F. and

the National Fund for Medical Education in 1951, $6,941,157.58 has been distributed to the nation's 80 medical schools in unrestricted funds for their operating budgets. Approximately one-half of this amount came from business and industry and the balance from the medical profession.

The Council approved the A. M. E. F. campaign in Ohio, and urged members of the Association to give it their active and liberal support.

FIFTY-YEAR AWARDS

Fifty-year certificates and emblems were passed out to members of The Council so they could arrange for presentation of the awards with the County Medical Societies involved.

Members of The Council then gave reports on activities in their districts and visits to county societies.

There being no further business, The Council adjourned.

Attest: CHARLES S. NELSON,
Executive Secretary.

Toledo Physician and Co-Worker Again Honored for Cartoon Strips

Dr. N. P. Dallis, Toledo, and Dan Heilman, creators of the nationally syndicated cartoon strip "Judge Parker," were cited by the American Bar Association for "talent and originality demonstrated in the accurate and engaging portrayal of the role of the lawyer and the judge in our society . . . and acute insight into the American system of equal justice under the law."

The two also were honored by the Freedoms Foundation with its annual award for "contribution to a better understanding of the American way of life."

The American Medical Association at its San Francisco meeting gave a similar citation for the strip "Rex Morgan, M. D.," created by the same two.

Zollinger Named Vice-Chairman of V. A. Advisory Group

Dr. Robert M. Zollinger, professor and chairman of the Department of Surgery, Ohio State University College of Medicine, was elected vice-chairman of the Special Medical Advisory Group of Veterans Administration, which met in Washington, D. C., September 13.

Dr. Donald E. Hale, head of the Anesthesiology Department, Cleveland Clinic, was named to represent his specialty in the group.

The Special Medical Advisory Group, which meets quarterly, was established by law to advise the V. A. administrator and the chief medical director on the policies and programs designed to insure the best possible medical care and treatment of disabled veterans. It consists of 20 members.

Advancement of Standards in Medical Writing Is Goal of Society

The American Medical Writers' Association, whose principal purpose is to help maintain and advance high standards of medical writing, held its 11th annual session in Chicago recently.

The Association was organized as the Mississippi Valley Medical Editors' Association in 1940. It has gone through several evolutionary changes to broaden its scope and in 1952 became an affiliated society of the American Association for the Advancement of Science. It has since grown rapidly until it now has a membership of over 500.

As a result of its efforts, three schools of journalism in the midwest are now offering four-year courses in medical journalism—the University of Illinois, University of Missouri and the University of Oklahoma. At these institutions, laymen who wish to make a career of this branch of science writing will be given basic training in the science of medicine as well as in the art of writing.

The training of lay medical writers, however, does not get at the nub of the problem namely, making better writers out of physicians themselves, Dr. Jonathan Forman, Editor of *The Ohio State Medical Journal*, told members of the Medical Writers' Association in Chicago.

"We must not let lay persons take over the writing of medical articles and texts," Dr. Forman asserted. He viewed with some alarm the exclusion of young physicians from the programs of local, state and national clinical meetings.

Dr. Forman further told the group that the trend is too much toward using only name men from distant places on programs in the hope that attendance can thus be maintained. "So too in the organizational journals," he said, "too much space is given over to older men and not enough trouble taken to see that younger men contribute well planned and well written reports of their experiences."

As chairman of the Advisory Council of the American Medical Writers' Association, Dr. Forman urged that the Association cooperate with various specialty societies and other interested groups in planning and conducting workshops at their meetings. Plans are now going forward to hold half-day workshops on medical writing at two national meetings of specialty societies.

Another service offered by the American Writers' Association is editing of manuscripts for its members.

Physicians interested in additional information or in becoming members are invited to write to Dr. Forman, in care of *The Ohio State Medical Journal;* or to Dr. Harold Swanberg, Secretary-Treasurer of the American Medical Writers' Association, 209-224 W. C. U. Bldg., Quincy, Ill.

Annual Meeting Schedule . . .

Program for 1955 Gathering in Cincinnati, April 19-22, Now Taking Shape; Day Set Aside in Midweek for Specialty Society Meetings

PLANS are beginning to take form for the 1955 Annual Meeting of the Ohio State Medical Association in Cincinnati, April 19, 20, 21 and 22.

The Committee on Scientific Work has held two meetings, one of which was a joint conference with officers of the various Scientific Sections. A conference also was held with representatives of the various specialty societies to plan for "Specialty Society Day" on Wednesday, April 19. This was an innovation at the 1954 Annual Meeting and met with a popular response.

Readers should refer to the minutes of meetings of The Council held on September 17, 18 and 19 (Page 1055) for complete details on the work of the Committee on Scientific Work to date.

As usual, the Netherland Plaza Hotel will be the headquarters hotel. It will house the Registration Headquarters, Technical Exhibit and Scientific and Educational Exhibit. General sessions and meetings of the House of Delegates will be at the Netherland, in addition to a number of section meetings. Space in other nearby hotels will be used for other section meetings.

Following is the schedule of events for the Cincinnati meeting, the complete program for which will be published in the March, 1955, issue of *The Journal*. Additional Annual Meeting information will be published monthly in *The Journal*.

SCHEDULE FOR 1955 MEETING

TUESDAY, APRIL 19

9:00 A. M.—Opening of Registration.
10:00 A. M.—Opening of Exhibits.
1:30 P. M. to 2:30 P. M.—Section on Surgery; Section on General Practice; Section on Nervous and Mental Diseases; Section on Ophthalmology; Section on Radiology.
2:30 P. M. to 3:00 P. M.—Intermission for Tour of Exhibits.
3:00 P. M. to 4:00 P. M.—Continuation of Section Meetings.
4:00 P. M. to 5:30 P. M.—Tour of Exhibits.
5:00 P. M.—First Session of House of Delegates.
7:00 P. M.—Complimentary Dinner for Delegates.

WEDNESDAY, APRIL 20

"Specialty Society Day"

9:00 A. M.—Opening of Registration Headquarters and Exhibits.
9:00 A. M. to 12:00 Noon—Continuous motion picture program of some of the latest and best scientific movies.
9:30 A. M.—Registration for Annual Conference of County Society Officers and Committee Chairmen.
10:00 A. M.—Program—Conference of County Society Officers and Committee Chairmen.
12:00 Noon—Luncheon for County Society Officers and Committee Chairmen.
1:30 P. M. to 2:30 P. M.—Section on Physical Medicine; Section on Otorhinolaryngology.
2:30 P. M. to 3:00 P. M.—Intermission for Tour of Exhibits.
3:00 P. M. to 4:00 P. M.—Continuation of Section Meetings.
4:00 P. M. to 5:30 P. M.—Tour of Exhibits.

(Wednesday afternoon and Wednesday evening available for meetings of specialty societies and Ohio Academy of General Practice for programs, business sessions and social events.)

THURSDAY, APRIL 21

9:00 A. M.—Opening of Registration Headquarters and Exhibits.
9:30 A. M. to 10:30 A. M.—Section on Anesthesiology; Section on Internal Medicine; Section on Neurological Surgery; Section on Obstetrics and Gynecology and Section on Urology (joint session); Section on Pediatrics.
10:30 A. M. to 11:00 A. M.—Intermission for Tour of Exhibits.
11:00 A. M. to 12:00 Noon—Continuation of Section Sessions.
2:00 P. M. to 3:00 P. M.—General Session.
3:00 P. M. to 3:30 P. M.—Intermission for Tour of Exhibits.
3:30 P. M. to 4:00 P. M.—Guest Speaker.
4:00 P. M. to 4:30 P. M.—Guest Speaker.
4:30 P. M. to 5:30 P. M.—Tour of Exhibits.
7:30 P. M. —Annual Banquet.

FRIDAY, APRIL 22

8:00 A. M.—House of Delegates Breakfast and Business Session.
9:00 A. M.—Opening of Registration and Exhibits.
9:30 A. M.—Guest Speaker.
10:00 A. M. to 10:30 A. M.—Intermission for Tour of Exhibits.
10:30 A. M. to 11:00 A. M.—Guest Speaker.
11:00 A. M. to 12:00 Noon—Panel Presentation on "Uses and Abuses of Cortisone and ACTH."

FIRST CALL FOR ENTRIES IN

Scientific and Educational Exhibit

1955 Annual Meeting, Ohio State Medical Association
April 19-22, Cincinnati, Ohio

OUTSTANDING among the features of the 1955 Annual Meeting of the Ohio State Medical Association, April 19, 20, 21 and 22, Cincinnati, Ohio, will be the Scientific and Educational Exhibit. This Scientific and Educational Exhibit will be at the Netherland Plaza Hotel.

This is a general invitation to members of the Ohio State Medical Association as well as others to participate. If you have display material which will be of scientific or general educational value, why not put it on display?

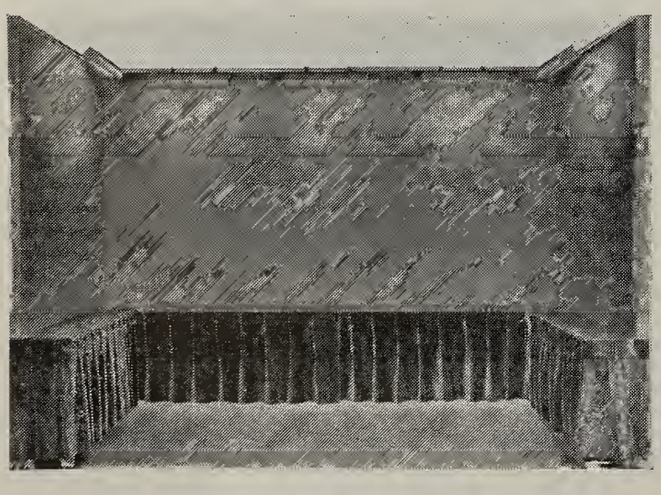
Exhibit material should fall in one of three categories: Original investigation, teaching value, or special educational value to physicians.

On the opposite page will be found an application blank. If you have material suitable for an exhibit send in an application. If you know of a colleague or group of physicians who have interesting material to display suggest that they do the same.

The Scientific and Educational Exhibit will be in the South Hall, Fourth Floor, Netherland Plaza Hotel.

Cost of transporting exhibits to the meeting must be borne by individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit. The Ohio State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, view boxes, current, furniture, decorations, etc., providing all items are approved in advance by the chairman of the committee. Watchman service will be provided for the exhibit.

Equipment and facilities similar to that used at A. M. A. meetings will be used. The accompanying picture shows the type of booth which will be provided.



Type of Booth To Be Used for Scientific Exhibits

Booths will be uniform color and design, solidly constructed of wood and wallboard and skirted with velour. A shelf will surround three sides with the upper area covered with taut blue crash fabric for bulletin board background. This material will permit the tacking or taping of charts and specimens without fear of damaging the exhibits. Fluorescent lights are a part of the background.

APPLICATION

For Space in the Scientific and Educational Exhibit

1955 Annual Meeting • Ohio State Medical Association

NETHERLAND PLAZA HOTEL CINCINNATI, OHIO APRIL 19-22, 1955

Fill Out and Mail to:

BRUCE G. MACMILLAN, M. D., *Chairman*
Committee on Scientific and Educational Exhibits
Christian R. Holmes Hospital
Eden and Bethesda Avenues,
Cincinnati 19, Ohio

DEADLINE FOR APPLICATIONS . . . FEB. 15, 1955

1. Title of Exhibit: _____
2. Description or nature of exhibit (attach 200-word description to this blank).
3. Will radiologic viewing boxes be needed? If so, state number and size:
   Number of boxes needed _____ Size required _____
   (Please indicate if you plan to furnish own view box.)
4. Will you require shelf space? If so, how much? _____
5. How much floor space will you require? _____
6. How much back wall space will you require? _____
7. How much side wall space will you require? _____
8. Other material or equipment required: _____
9. Name of exhibitor: _____
   _____ (Street) _____ (City)
10. Name of institution cooperating in exhibit (if desired):

_____

_____

_____

_____

Booths will have a back wall and two side walls. The side walls of all booths will be four feet wide. The back wall of most of the booths will be 8 feet long; a few will be somewhat smaller. If an exhibitor needs more space, or a space with special dimensions, he should explain in detail in writing to the Exhibit Chairman. In most instances, the standard booth should be sufficient.

The height of the back and side walls will be eight feet. However, because of the standard shelf in all booths, only five and one-half feet of wall space will be suitable for exhibit material.



Going to Cinc'y . . . ? . . .

for the 1955 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION? The dates are Tuesday-Friday, April 19-22, but it's an excellent idea to make HOTEL RESERVATIONS well in advance. This list of leading downtown Cincinnati hotels is given for your convenience. Clip the coupon at the bottom of this page and mail it to the hotel of your choice with your specifications.

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BEDS
NETHERLAND PLAZA HOTEL	$5.50-12.00	$10.00-12.00	$10.50-15.50
ALMS HOTEL			$ 8.00-10.00
BROADWAY HOTEL	$3.50	$ 5.50- 6.50	$ 7.50-10.00
CINCINNATIAN HOTEL	$3.00- 5.00	$ 4.00- 7.00	$ 5.00- 8.00
METROPOLE HOTEL	$5.00- 8.00	$ 7.50- 9.00	$ 8.50-11.00
SHERATON-GIBSON HOTEL	$5.35-12.35	$ 8.35-12.35	$ 9.35-15.85
SINTON HOTEL	$4.35-11.35	$ 6.85-11.35	$ 9.85-14.85
TERRACE PLAZA HOTEL	$9.50-15.00		$12.50-18.00
VERNON MANOR	$4.00	$ 5.00- 6.00	$ 6.00- 9.00

Persons who desire suites or other additional accommodations are advised to specify their needs to the hotel of choice.
(All rates subject to change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager..... Hotel, Cincinnati, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 19, 20, 21, 22, 1955, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price .....

☐ Twin Bed Room with Bath ☐ Additional Accommodations (Specify)

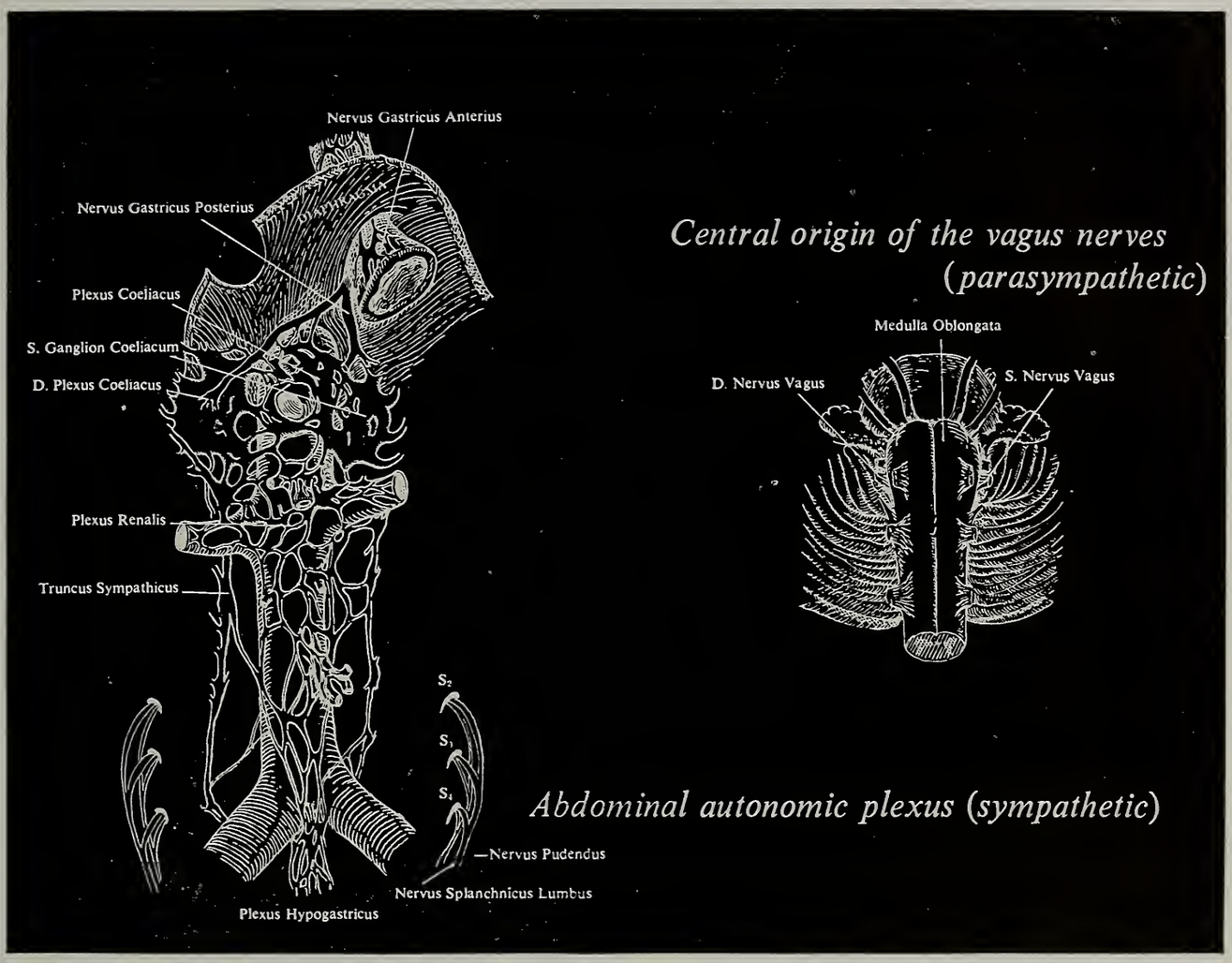
Arriving April..... at..... A.M..... P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address .....

.....



Control of Gastric Motility and Spasticity in Peptic Ulcer with Banthine®

"The need[1] for suppressing gastric motility and spastic states is . . . fundamental in peptic ulcer therapy. Since the cholinergic nerves are motor and secretory to the stomach and motor to the intestines, agents capable of blocking cholinergic nerve stimulation are frequently used to lessen motor activity and hypermotility."

Banthine[2] "has dual effectiveness; it inhibits acetylcholine liberated at the postganglionic parasympathetic nerve endings and it blocks acetylcholine transmission through autonomic ganglia."

It has been shown[1] to diminish gastric motility and secretion significantly as well as intestinal and colonic motility.

The usual schedule of administration in peptic ulcer is 50 to 100 mg. every six hours, day and night, with subsequent adjustment to the patient's needs and tolerance. After the ulcer is healed, maintenance therapy, approximately half of the therapeutic dosage, should be continued for reasonable assurance of nonrecurrence.

Banthine® (brand of methantheline bromide) is supplied in: Banthine ampuls, 50 mg.—Banthine tablets, 50 mg.

It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Searle Research in the Service of Medicine.

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1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. *147*:1620 (Dec. 22) 1951.

New Military Program . . .

Use of Young Doctors in Armed Forces, When and If, Doctors' Draft Act Expires Is Agreed Upon; Limited Number Permitted Residency Training

LOOKING forward to the possibility that the so-called Doctors' Draft Act will be permitted to expire next June 30, the Department of Defense and the Selective Service System have agreed on a program which will insure that the Armed Forces will continue to receive medical officers who have had residency training in certain fields.

Known as the "Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program," this program will permit a limited number of young physicians, completing internship, who are regular registrants under the Universal Military Training and Service Act (regular Selective Service Act), to complete residency training prior to being called to active military duty.

It will be the policy of Selective Service to recommend the deferment of such registrants who may be selected by the Assistant Secretary of Defense (Health and Medical) for essential residency training. Selected registrants will be certified to the Selective Service System with a request for deferment. Names will be forwarded to local boards through state directors of selective service.

BULLETIN ISSUED

The new program and how it will operate are described in the following information bulletin issued by the Department of Defense and sent to physician registrants under the regular Selective Service Act:

"The following information is applicable to physicians who are liable for military service in accordance with the provisions of the Universal Military Training and Service Act, as amended, and who are graduates of schools of medicine approved by the American Medical Association.

"In the event the Doctor Draft is not extended beyond 1 July 1955, the only physicians liable for duty will be those who have been deferred previously from induction by the Selective Service System to complete their medical schooling and one year of internship. Under the provisions of the Universal Military Training and Service Act, as amended, all members of the 1954-55 Interne Class who have been deferred may be inducted into the military service at any time after completion of internship.

WILL NEED REPLACEMENTS

"The Department of Defense is desirous of receiving only the number of physicians that can be efficiently utilized. In this respect, requirements for physicians (to replace medical officers whose terms of service expire) extend throughout the year; and, in addition, the Armed Forces require some physicians with partial or completed specialty training.

"It is realized that obligated physicians may have definite choices for the military department in which they desire to fulfill their military service; choices as to the time they wish to enter military service following completion of internships; and some desire residency training before entering military service.

EXCESS FOR RESIDENCIES

"As a solution of these problems the Selective Service System has agreed to assist the Department of Defense to provide that physicians obligated for military service and who are commissioned as reserve officers be ordered to duty as needed throughout the year following completion of internship, and if more physicians are available than needed to fill requirements, that the excess may be considered for deferment for essential residency training as a joint action of the Department of Defense and the Selective Service System.

"This solution or plan will be known as the 'Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program.' Those obligated physicians who do not become reserve medical officers will be subject to general induction calls placed by the Department of Defense with the Selective Service System. Physicians who are not reserve medical officers will not be considered for deferment for essential residency training nor may they be given any assurance as to choice of military department for service.

HOW THE PLAN WILL WORK

"Accompanying this information bulletin is the basic form, 'Statement of Service Preference.' In order for this program to work efficiently for you, it is imperative that this and other forms you may receive, be read carefully, accurately filled in, and returned promptly in accordance with instructions on the bottom of each form.

CAN SELECT BRANCH OF SERVICE

"Answers to Part I of this form will establish your status as a reserve medical officer or desire to become a reserve medical officer; your order of choice for the military department in

The Combining Potential of

VERILOID®

in the treatment of hypertension

The effectiveness and notable safety of Veriloid (the original alkavervir fraction of Veratrum viride) make it particularly well suited for combination therapy in moderate to severe essential hypertension. The antihypertensive action of Veriloid is potentiated when the drug is used with other agents;[1,2,3,4] hence smaller dosage of each, Veriloid and the comedication, yields a combined effect more potent than either drug alone when used in full dosage.[1,2,4]

Veriloid may be combined with sedative agents, with hydralazine, or with hexamethonium, resulting in lower dosages required for each.

Says a recent report[4] regarding the concomitant use of Veriloid with hydralazine: "In a few cases the addition of Veriloid permitted the use of a smaller dose of Apresoline. In other cases, after the addition of Veriloid, more hydralazine could be used with a resultant improvement in blood pressure response. There were [5] instances where...the blood pressure was lowered beyond that obtained with the latter drug alone."

Veriloid is supplied in 2 mg. and 3 mg. slow-dissolving scored tablets. When used as sole medication, initial daily dosage is 8 or 9 mg. in divided doses, not less than 4 hours apart, preferably after meals.

When used in combination with other antihypertensive drugs, the dosage of Veriloid may be reduced by as much as 50%.[1]

1. Allen, E.V.; Barker, N.W.; Hines, E.A., Jr.; Kvale, W.F.; Shick, R.M.; Gifford, R.W., Jr., and Estes, J.E., Jr.; Proc., Staff Meet. Mayo Clin. *29*:459 (Aug. 25) 1954.
2. Livesay, W.R.; Moyer, J.H., and Miller, S.I.: J.A.M.A. *155*:1027 (July 17) 1954.
3. Wilkins, R.W.: Mississippi Doctor *30*:359 (Apr.) 1953.
4. Kert, M.J.; Rosenfeld, S.; Mailman, R.H.; Westergart, J.P.; Carleton, H.G., and Hiscock, E.: Angiology *5*:318 (Aug.) 1954.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Riker LABORATORIES, INC., LOS ANGELES 48, CALIF.

which you desire to serve; or your desire to be deferred for residency training.

"Answers to Part II of the form will permit consideration of your desire for deferment for residency training. Under paragraph 7 of Part II of this form be sure to state specifically the type of residency training you desire; i. e., Internal Medicine, General Surgery, Obstetrics and Gynecology, etc., and state whether you wish to be deferred for one, two, or three years to pursue this training. Do not say 'Undecided' or 'Two or three years'—be specific, otherwise your name cannot be considered for deferment for residency training.

"For specialties requiring training in general surgery, initial deferment for training in General Surgery must be entered, and give specialty in parenthesis. Continued training in the specialty of choice will be by selection based upon performance during general surgery residency and the exigencies of the Service to which the applicant may be allotted.

SECURE OWN RESIDENCY

"It is necessary for you to arrange for your own residency in the institution of your choice. In order to be acceptable under this program, this residency must be fully approved by the Council on Medical Education and Hospitals of the American Medical Association and the American Specialty Board concerned for the period of training desired.

"Upon return of the 'Statement of Service Preference' and in accordance with your desire you will be furnished an 'Application for Reserve Commission' from the military department of your choice, as practicable.

"If you have indicated a desire for residency training under this program and are selected for residency training under the program you will be notified and furnished two remaining forms: i.e., 'Request for Deferment for Residency Training' and a 'Hospital Agreement' form. These forms must be completed and returned to the Department of Defense in accordance with instructions on the bottom of the forms. Those applicants not selected will be so notified.

IN INACTIVE RESERVE STATUS

"The names of all registrants who request deferment will be submitted to the hospital of their selection and the hospital will be requested to indicate to the Assistant Secretary of Defense (Health and Medical) their preference within available quotas. Those who are deferred and who are in a civilian hospital for the purpose of obtaining residency training will be in an inactive Reserve status and will receive neither pay nor allowances from the service in which they hold their Reserve commission. They are therefore eligible to receive the normal stipend that the civilian hospital pays its residents. They will wear civilian clothes during their period of residency and will not be in uniform until they are called to active duty on completion of their deferment.

TWO YEARS SERVICE

"There is no obligation to the Armed Forces for participation in this program other than the two years of active service which are required of registrants under the Universal Military Training and Service Act, as amended, which will be served on completion of deferment. Again, the number of residents under this program will depend upon the excess number of registrant physicians who are available to fill the requirements of the Armed Forces for physicians during any one year."

Dr. Hattery To Be Honored In Mansfield Meeting

The Richland County Medical Society and Auxiliary will be host to physicians and their ladies of the Eleventh Councilor District in a gathering to honor Dr. John S. Hattery, Mansfield, former Councilor of the District. The dinner meeting is scheduled to be held in the Mansfield-Leland Hotel, Mansfield, on Thursday, November 18.

Dr. Hattery retired from The Council of the O. S. M. A. after serving the maximum of three terms as District Councilor. He also served several years as a member of the Advisory Committee to the State Auxiliary.

Headline speaker for the occasion will be Dr. Charles P. Bailey, professor in the Department of Surgery, Hannemann Medical College, Philadelphia, who will describe techniques in cardiac surgery.

A feature of the occasion will be a clinical session at the Mansfield General Hospital beginning at 2:30 in the afternoon.

Opinion of the Attorney General

The following opinion was given recently by Attorney General C. William O'Neill:

Opinion No. 4177: Where pursuant to Section 4126 of the General Code (Section 753.02, Revised Code) the commissioners of a county have entered into a contract with a city whereby the county leases to said city a certain portion of the cells in the county jail for the confinement of prisoners sentenced for violations of ordinances of said city, which contract obligates the county to provide for the custody and maintenance of such prisoners at an agreed charge to be paid by said city, and said contract contains no reference to the cost of hospital or medical services that may be required for such prisoners, it is the duty of the county to furnish such services at its own expense.

Ohio Academy of General Practice . . .

Dr. Jarvis Named To Head Organization Next Year; Other Officers Also Elected; House of Delegates Takes Action on Policy Matters

THE Ohio Academy of General Practice at its annual meeting in Columbus, September 22-23, named Dr. James R. Jarvis, Van Wert, president-elect. He will assume the presidency at the annual meeting in Dayton next year. Dr. Jarvis also is on The Council of the Ohio State Medical Association, as Councilor of the Third District.

Dr. Herbert W. Salter, Cleveland, assumed the presidency at the meeting, succeeding Dr. George H. Lemon, Toledo. Other persons elected to State offices are: Dr. Howard M. Mitchell, Sr., Columbus, treasurer; Dr. Earl C. Van Horn, Cincinnati, speaker of the House; Dr. Lewis W. Cellio, Columbus, vice-speaker. Dr. Earl D. McCallister, Columbus, is executive secretary of the Academy.



J. R. JARVIS, M. D.

Dr. Gordon L. Erbaugh, Dayton, was elected delegate to the American Academy of General Practice, with Dr. Herbert W. Salter, alternate.

Delegates from the even-numbered districts were elected as follows: Second District, Dr. Roscius C. Doan, Miamisburg (reelected); Fourth, Dr. Gwyn H. Start, Toledo; Sixth, Dr. Glenn C. Dowell, Canton; Eighth, Dr. Robert S. Bode, Rushville (reelected); Tenth, Dr. Clarence M. Gallagher, Columbus. Dr. David L. Steiner, Lima, was named delegate from the Third District to succeed Dr. Jarvis.

Among speakers at the meeting were Dr. M. D. Prugh, Dayton, President of the Ohio State Medical Association, and Dr. David W. Heusinkveld, Cincinnati, President-Elect of the Ohio State Medical Association, who gave the address of welcome. Approximately 620 persons attended, of whom 412 were Doctors of Medicine.

ACTIONS OF HOUSE

The House of Delegates passed, by unanimous vote, a resolution supporting the American Medical Association and other medical and professional organizations in a firm stand against compulsory inclusion of self-employed groups under the federal social security program, but which action does not deprive an individual of electing social security for himself.

By unanimous approval a slogan was adopted, "A Family Doctor For Every Doctor's Family." This slogan originated by an official of the American Academy of General Practice, the late Merrill Shaw, M.D., was adopted at the June 1954 meeting of the House of Delegates of the American Medical Association when presented by resolution by the American Academy of General Practice.

In order to promote public relations the Academy approved a resolution to take an active part, through its local chapters, in making approved printed material available for Academy and/or county medical society booths at County Fairs where requested.

The House of Delegates approved the plan to devise an identification card, through proper channels, to contain data of mutual interest to the patient, hospital, and medical profession. This card could be presented to the patient by the family doctor, and would have the name of patient, address, date issued, name of family physician, the blood type, and other medical data of importance such as diabetes, cardiac, etc.

University of Florida Schedules Midwinter EENT Sessions

The ninth annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of January 17. The lectures on Ophthalmology will be presented on January 17, 18, and 19 and those on Otolaryngology on January 20, 21, and 22.

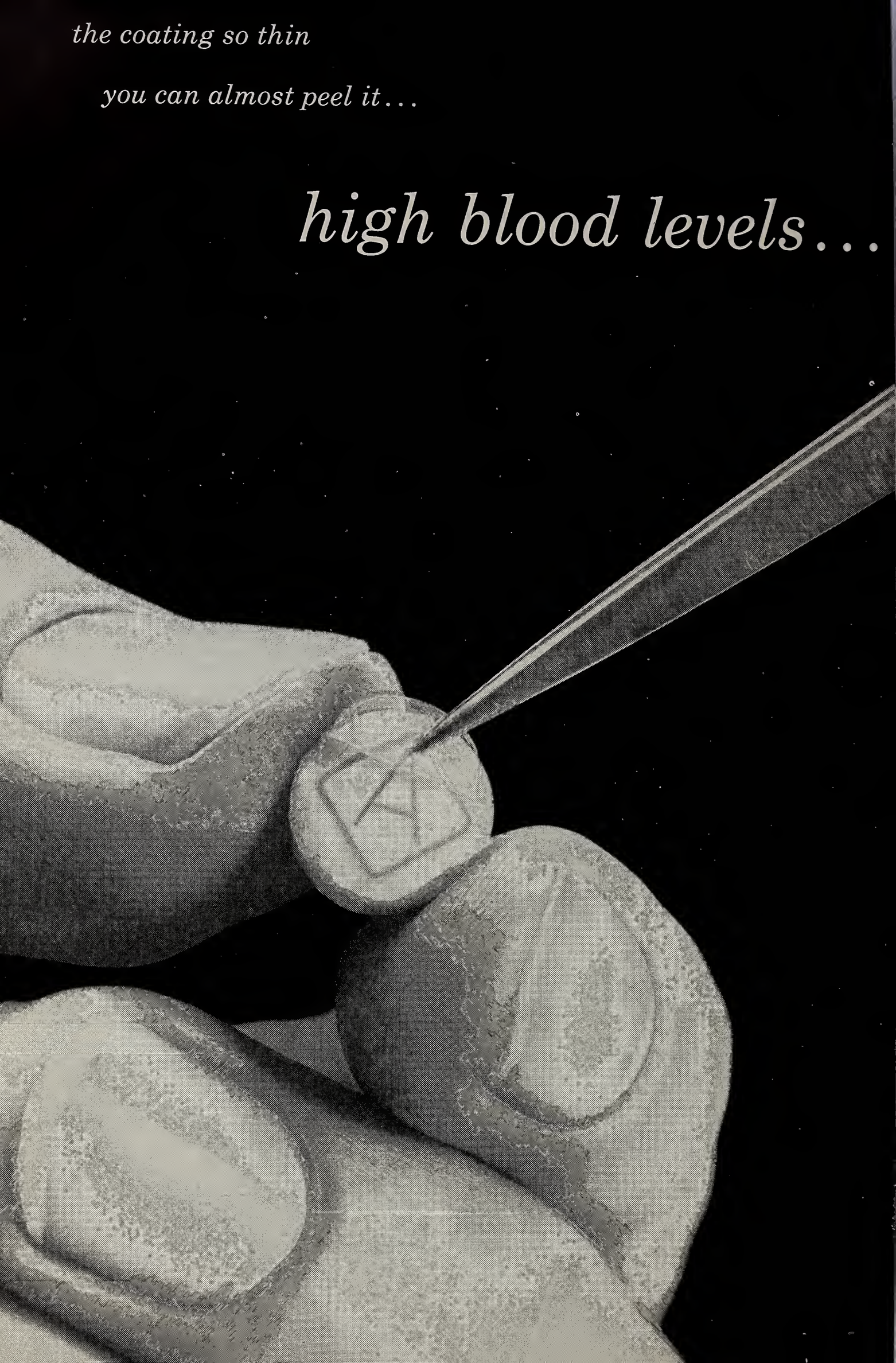
A midweek feature will be the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 19, to which all registrants are invited. The registrants and their wives may also attend the informal banquet at 8 p. m. on Wednesday. The Seminar schedule permits ample time for recreation.

The Seminar lecturers on Ophthalmology this year are: Dr. William F. Hughes, Jr., Chicago; Dr. Phillips Thygeson, San Jose; Dr. James Allen, New Orleans; Dr. Walter H. Fink, Minneapolis; and Dr. Milton L. Berliner, New York. Those lecturing on Otolaryngology are: Dr. Paul Holinger, Chicago; Dr. Lawrence R. Boies, Minneapolis; Dr. Edmund P. Fowler, Jr., New York; Dr. Arthur W. Proetz, St. Louis; and Dr. David D. DeWeese, Portland, Oregon.

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Intern-Residency Training . . .

More Physicians Than Ever Are Taking Full-Time Graduate Work. A. M. A. Report Shows; Data on Approved Ohio Hospitals Given

THERE are now 75 per cent more physicians in full-time graduate training in U. S. hospitals than there were 10 years ago, the 28th annual report of the A. M. A. Council on Medical Education and Hospitals reveals, in the September 25 issue of *The Journal of the A.M.A.*

On the first of this year there were about 26,000 interns and residents training in hospital staff positions, compared to about 15,000 in 1945.

During the same period, the number of openings for full-time graduate work doubled. On January 1, 1954, there were 34,172 openings compared to 16,095 in 1945. As of September 1, 1954, a total of 33,985 positions were open for the 1954-55 year, including 22,763 residencies and fellowships, and 11,222 internships. Residency openings decreased from 23,630 last year, and internships increased from 11,006.

In Ohio for the school year 1953-1954, there were 49 hospitals approved for internship training. There were 525 internships filled on January 15, or 81 per cent of the number of openings. This compared favorably with the national average of 78 per cent of openings filled.

IN OHIO HOSPITALS

As of September 1, the same number of approved hospitals in Ohio (49) were offering 678 internships. (The report did not indicate the number filled.)

Ohio's internships are rotating general with the following exceptions: Bethesda Hospital, Cincinnati, offers eight rotating general and two mixed (med.-ob.-surg.); University Hospitals, Cleveland, offers 16 rotating general, 12 straight medicine, 8 straight surgery and 2 straight pediatrics.

Detailed information on Ohio hospitals approved for internship training may be found on pages 337-338 of the September 25 issue of *The Journal of the A. M. A.*

Sixty-six Ohio hospitals are approved for residency and fellowship training. The list of these hospitals and the types of residency offered by each may be found on page 426 of the September 25 *Journal of the A. M. A.*, also under the various specialty headings in the same report.

OPENINGS COMPARED WITH APPLICANTS

The national report further reveals that in 1945 applicants filled about 15,000, or more than 90 per cent of the openings. In 1952-53 they filled about 74 per cent, or 26,894 of the positions. The council said this indicated a fundamental problem—the opportunities for intern and resident service had been increasing more rapidly than the number of available applicants. However, the percentage of filled positions increased to about 79 for the 1953-54 year.

The council helps provide better medical care by approving for training programs only hospitals meeting satisfactory basic educational and clinical standards. As of January 1, there were 1,347 approved hospitals offering such training.

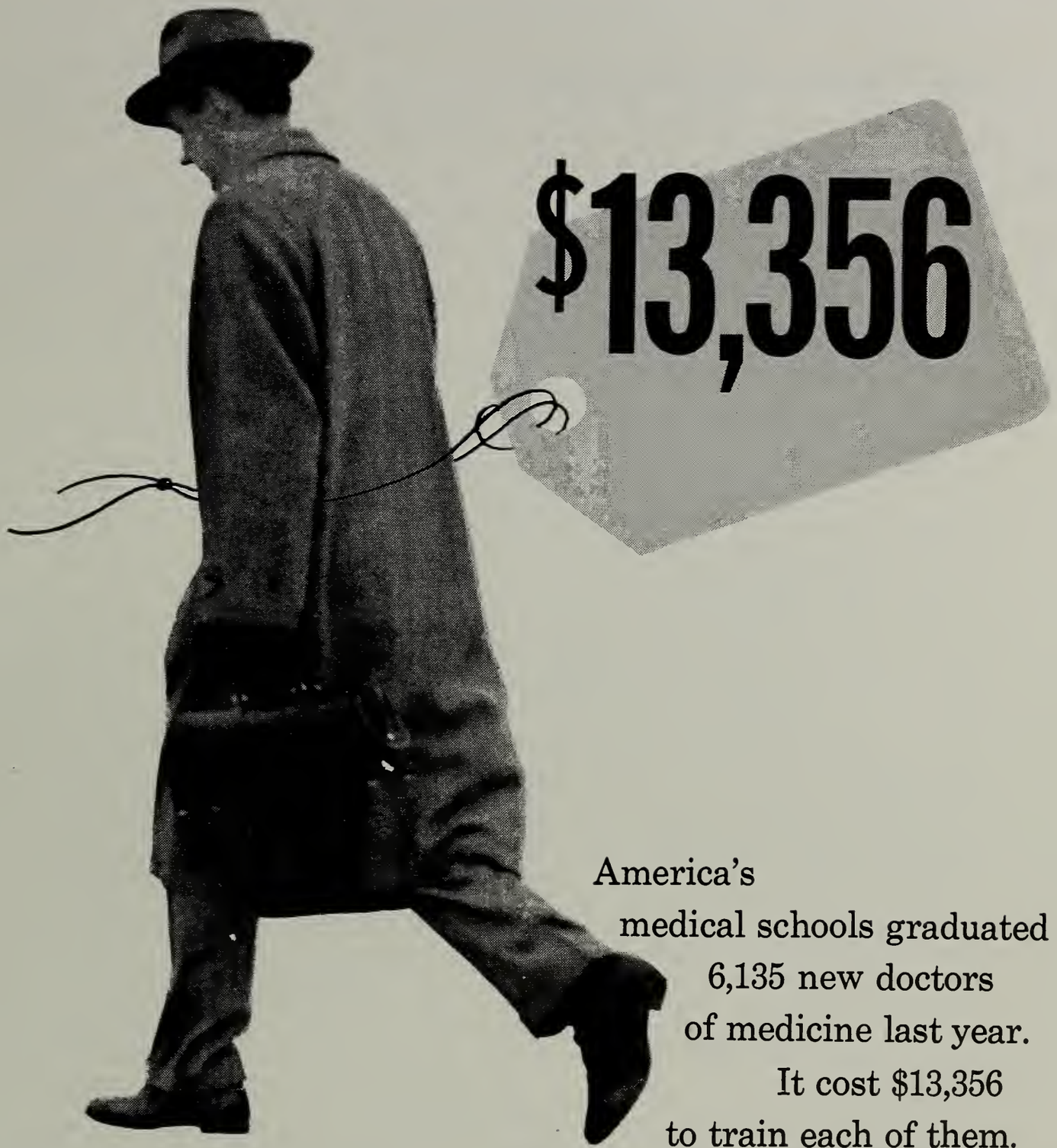
Hospitals offering internship programs increased only 7 per cent in 10 years, while the number of available positions rose 26 per cent. The council said the number of positions offered varies from year to year depending on the demand for staff members by approved hospitals. It said this suggests that careful self-appraisal by hospitals of their individual needs could result in "a sharp decline if not in the elimination of" the present excess of positions available. This appraisal should be from the standpoint "not alone of services required but of their potential for providing a worth-while educational experience for these graduates."

About 90 per cent of the interns entered rotating programs designed to lay a foundation for general practice residencies or further specialty training. The trend toward higher pay for interns seemed to be slowing, the council said. Last year 44 per cent of the hospitals paid more than $150 a month; this year 30 per cent paid that. However, hospitals paying more than $200 had a lower occupancy rate for their positions than the lower-salary hospitals, indicating that the salary level "is not a decisive factor in attracting an intern staff."

Dr. Seligman To Address Michigan Academy of General Practice

Dr. Bert Seligman, senior surgeon in vascular surgery at Flower Hospital, Toledo, will be one of the leading speakers at the Eighth Annual Postgraduate Clinic of the Michigan Academy of General Practice in Detroit, November 10-11. His subject will be "Trypsin; an Anti-Inflammatory Agent."

The meeting will be held in the Sheraton-Cadillac Hotel beginning at 8:00 a. m. on Wednesday, November 10. There will be 16 speakers on the program as well as exhibits and other interesting features.



America's
medical schools graduated
6,135 new doctors
of medicine last year.
It cost $13,356
to train each of them.

Most of this becomes medical school operating deficit which we as a profession must help meet. We will send your contribution along to the medical school of your choice if you prefer.

American Medical Education Foundation

535 North Dearborn Street, Chicago 10

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

ARE YOU PREPARED TO HANDLE OCCUPATIONAL DISEASES?

In this issue of *The Journal* will be found an excellent article on "Occupational Diseases" by Dr. Thomas F. Mancuso, chief of the Division of Industrial Hygiene, Ohio Department of Health. It should be of intense interest to thousands of physicians throughout Ohio.

This article is the "kick off" of a series of articles which will be presented by *The Journal* on this general subject. Some have been prepared by Dr. Mancuso at the request of *The Journal.* The articles will be in the form of abstracts of monographs on specific toxic substances causing occupational diseases and presenting health hazards in industry.

Another article in this field is one written by Dr. Rex H. Wilson, medical director of the B. F. Goodrich Company, Akron, on the subject "Prevention in the Occupational Health Program," which will appear in an early issue of *The Journal.*

It is becoming increasingly important for Ohio physicians, general practitioners and specialists alike, to increase their knowledge about the causes of occupational diseases and industrial health hazards. All must strive to improve their skill in handling patients who are exposed to these hazards. Ohio has a large industrial population. The workers are scattered. They reside in almost every community of the state. This means that physicians in both large and small communities must be prepared to meet the growing problems arising from the use of many new and highly toxic substances in industrial processing.

The Journal deeply appreciates the willingness of these physicians to make this information available for publication. Moreover, it is delighted to be able to give members of the Association up-to-date and pertinent information on this important phase of the practice of medicine in today's industrial era.

GIVE NOW; MEDICAL SCHOOLS NEED SUPPORT OF ALL DOCTORS

Have you made your contribution to the American Medical Education Foundation? You'll recall receiving a letter recently from Dr. Merrill D. Prugh, President of the State Association, soliciting your support of the Foundation.

Here's your chance to strike a blow for medical freedom. You know that medical schools are having a tough time financially due to rising costs and decreased income from endowments. They need your help, either through A. M. E. F. or directly to the alumni fund of your school. The issue is clear. It's either a case of private support or Federal subsidy.

In 1953, a total of 542 Ohio physicians contributed $25,958 to A. M. E. F., and 2,089 gave $103,066.67 directly to their own schools. That's not a very good showing, when you consider that membership in O. S. M. A. is approximately 8,200.

If you have misplaced the pink envelope which accompanied Dr. Prugh's letter, here's the address of A. M. E. F.—535 N. Dearborn St., Chicago. Your gift will be just as acceptable in your own envelope! Remember that you can earmark your gift for your own medical school. Remember too, that it's an income tax deduction.

HOW ABOUT SEVERAL SUBSCRIPTIONS FOR "TODAY'S HEALTH"?

In our opinion, one of the best magazines in circulation today in the field of promoting good public relations for the medical profession and for the advancement of good medicine and good health is *Today's Health,* published by the American Medical Association.

The magazine is edited for the lay public and emphasizes their personal need for a family doctor and the community's need to suppress medical fraud and quackery.

Each physician, obviously, should have one or several copies in his waiting room. A copy should be in every public library and in college and university libraries. Clubs (male and female), civic groups, rural organizations, youth organizations, business and industrial firms, etc., should have a copy, or copies, on file for their members. Many other spots, too numerous to mention, could be listed.

If necessary, physicians should purchase subscriptions for some of these outlets in their respective communities. Subscriptions to *Today's Health* are nice gifts.

Promotion of *Today's Health* is one of the major activities of the Woman's Auxiliary to the Ohio State Medical Association. Members of the Auxiliary deserve the support of their husbands in their efforts to boost the circulation of *Today's Health.*

In a recent letter to various local Auxiliaries, Mrs. V. R. Frederick, Urbana, chairman, National Publications, for the O. S. M. A. Auxiliary, asking them to "get busy," Mrs. Frederick made these pertinent observations:

"Your doctor-husband can gain much more through *The Journal of the A. M. A.*, which is written specifically for him, than he can through

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Today's Health, but even for doctors, it has value. If his patients have read of cardiac ailments or obesity in *Today's Health,* it is much easier for a doctor to explain the procedure necessary in treating such ailments. If the patient is alerted to the dangers of untreated cancer, he will seek the early advice of his doctor—your husband. For the same reason, *Today's Health* is valuable to you, a doctor's wife.

"This is the day of preventive medicine. But laymen need authoritative information. Our busy doctors cannot spend valuable time searching out those in need of preventive treatment. The public must be instructed in health requirements so that they will seek early medical care of chronic ailments. It's up to the Auxiliary to be promotion agents for our husbands in their support of good health measures."

NEW TELEPHONE PRESCRIBING PROCEDURE NOT EFFECTIVE AS YET

It'll be quite some time before the new Federal law to allow prescribing of certain minor narcotics by telephone can become effective. A list of drugs must be compiled by the U. S. Bureau of Narcotics with the advice of representatives of certain professional groups. That will take time.

Also, there is a possibility that the state laws on narcotics and barbiturates may have to be revised in order to make the new Federal law effective in Ohio.

Therefore: Hold your horses.

When telephone prescribing procedure has been worked out, proper information will be publicized to the membership.

WE'RE SORRY; WRONG CONCLUSION DRAWN

On Page 977 of the October issue of *The Journal,* there appeared an "In Our Opinion" which was headed "Ways To Reduce Days in Hospital Suggested," based on an article which appeared originally in the August issue of the *Montgomery County Medical Society Bulletin.*

The *OSMA Journal* article erroneously inferred that the average length of stay of Blue Cross patients in Montgomery County hospitals was one-half day longer than the national average.

The facts are that the longer-than-average stay figure is based on statistics **for all hospitals in Southwestern Ohio** serving subscribers for Hospital Care Corporation, the Blue Cross Plan operating in that part of the state. Also, the facts are that the average hospital stay of Blue Cross patients in Montgomery County is slightly less than the national average—a commendable record.

The Journal apologizes to all concerned for having garbled the figures and published a misleading inference.

EDICT ON DRUGSTORE OWNERSHIP BY PHYSICIAN

A member wrote the Columbus Office recently wanting information and advice about participation in the ownership of a drugstore. He was given the following information, quoted from the Principles of Medical Ethics as revised at the recent San Francisco meeting of the A. M. A. House of Delegates:

"It is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. This inadequacy must be confirmed by his component medical society. The same principle applies to physicians who dispense drugs or appliances. In both instances, the practice is unethical if secrecy and coercion are employed or if financial interest is placed above the quality of medical care. On the other hand, sometimes it may be advisable and even necessary for physicians to provide certain appliances or remedies without profit which patients cannot procure from other sources."

WATCH FOR TAX STORY IN DECEMBER O. S. M. A. JOURNAL

A detailed story on taxes owed by physicians, how to make out forms, etc., will be published in the December issue of *The Journal.* Special emphasis will be given to the new Federal Income Tax Law. You'll want to review the article carefully. Watch for it. It will give you a good bird's-eye view of all the tax laws and regulations—Federal and state.

Of course, physicians will want to get proper legal and tax advice in addition to reading *The Journal* article. It will cover the question only in a general way; not attempt to answer special, personal problems. The story is being prepared with the help and cooperation of representatives of the office of the Columbus Collector of Internal Revenue. For that reason, it will be an accurate analysis. But, as already stated, it will not get into individual problems of the physician, especially one whose finances differ from the average.

FIGURES ANSWER CRITICS OF MEDICAL SCHOOLS

Only 21 per cent of the freshmen entering medical school last year had "A" averages in their pre-medical studies; 69 per cent had "B" averages, and 10 per cent had "C" averages. This knocks into a cocked hat the statements made too often by the uninformed that medical schools have a wall built around them and that only Phi Beta Kappas can enter.

Most young people who have the character, a burning desire to enter medicine, and a reasonable scholastic record can, and do, get into medical school.

Surely, even those who are habitual critics of medical education would not wish dilution to the danger point.

LONG BEFORE HOT FLUSHES APPEAR . . .

Patients presenting such classic menopausal symptoms as hot flushes cause little diagnostic difficulty. However, throughout the period of declining ovarian function which may begin long before hot flushes appear, many women complain of distressing symptoms which though less clearly defined are actually due to estrogen deficiency. For example, insomnia, headache, easy fatigability, and symptoms affecting the bones, joints, and the skin may not be readily identified as due to estrogen deficiency because they may occur years before, or even years after cessation of menstruation.

Investigators[1,2] have found that as the body attempts to adjust itself to declining estrogen production, a number of symptoms may appear which call for the prompt institution of estrogen replacement therapy. These symptoms may be nervous, circulatory, arthralgic, or dermatologic in character because the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism"[3] and affects many body functions. If such metabolic imbalance or deficiency is evidenced, the administration of estrogen is clearly indicated.

"PREMARIN" presents the complete equine estrogen-complex as it naturally occurs. "Premarin" not only produces prompt symptomatic relief, but it also imparts a gratifying and distinctive "sense of well-being." It has no odor . . . imparts no odor.

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Estrogenic substances (water-soluble), also known as conjugated estrogens (equine). Available in both tablet and liquid form.

1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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Program for Preschool Blind . . .

Coordinated Program Set Up by Division of Social Administration With Cooperation of Many Groups; Principles Drafted; Coordinator Appointed

STATE-WIDE coordination of physicians in private practice and public health, education, and welfare services for preschool blind children and their parents is the primary function of a new program being developed by the Division of Social Administration, Ohio Department of Public Welfare. The program will be designed to draft and provide the services most valuable to parents and professional persons interested in the young blind child and in helping him to adjust himself.

The need for coordination of services was determined by a survey in which parents, physicians, nurses, and other professional persons participated. In addition to information on the incidence and nature of blindness, the survey revealed many other important facts. Parents expressed their desire for counseling service immediately following the diagnosis of their child's blindness. They believed that their own attitudes, resulting from various degrees of emotional shock, greatly handicapped the child's healthy personality development. They questioned their own competence to help their child, and wondered about his education. Some parents in urban areas reported finding comfort, support, and encouragement through meeting with other parents of preschool blind children and sharing problems and hopes.

A Coordinator, Services for Preschool Blind Children, Edith H. Monroe, has been employed in the Division of Social Administration. An Advisory Committee has been appointed by Robert Canary, chief of the Division, to assist in formulating policies to guide the new program. The Committee is composed of parents of preschool blind children, and professional persons who have specialized in pediatrics, ophthalmology, public health, special education, casework, child development and administration of agencies dealing with the problems of blindness.

TENTATIVE PROGRAM

Program Planning is still in the formative stage, but some general principles and objectives have been established upon which services are being developed. The general principles accepted by the Advisory Committee are:

1. The focus of all services will be kept upon the individual child's total development and needs.

2. A complete and accurate registry of all blind children of preschool age will be kept and regarded as confidential. Any information concerning a child will be given to others only with the consent of the parents.

3. Parents' right and responsibility to decide the best plan for their child's health, education and welfare will be respected.

4. Pertinent facts and current information concerning all factors relating to blind children will be assembled and distributed for the use of parents and others concerned to assist them in making the most constructive choice of all resources available.

5. Emphasis will be placed on interpreting the cooperative services necessary to help the preschool blind child and his parents so that there will be growing public understanding and support to improve or extend services in keeping with the problems presented.

6. Assisting parents groups in their efforts better to understand and meet the needs of their blind children will be considered an important service. These groups may be considered also as a resource.

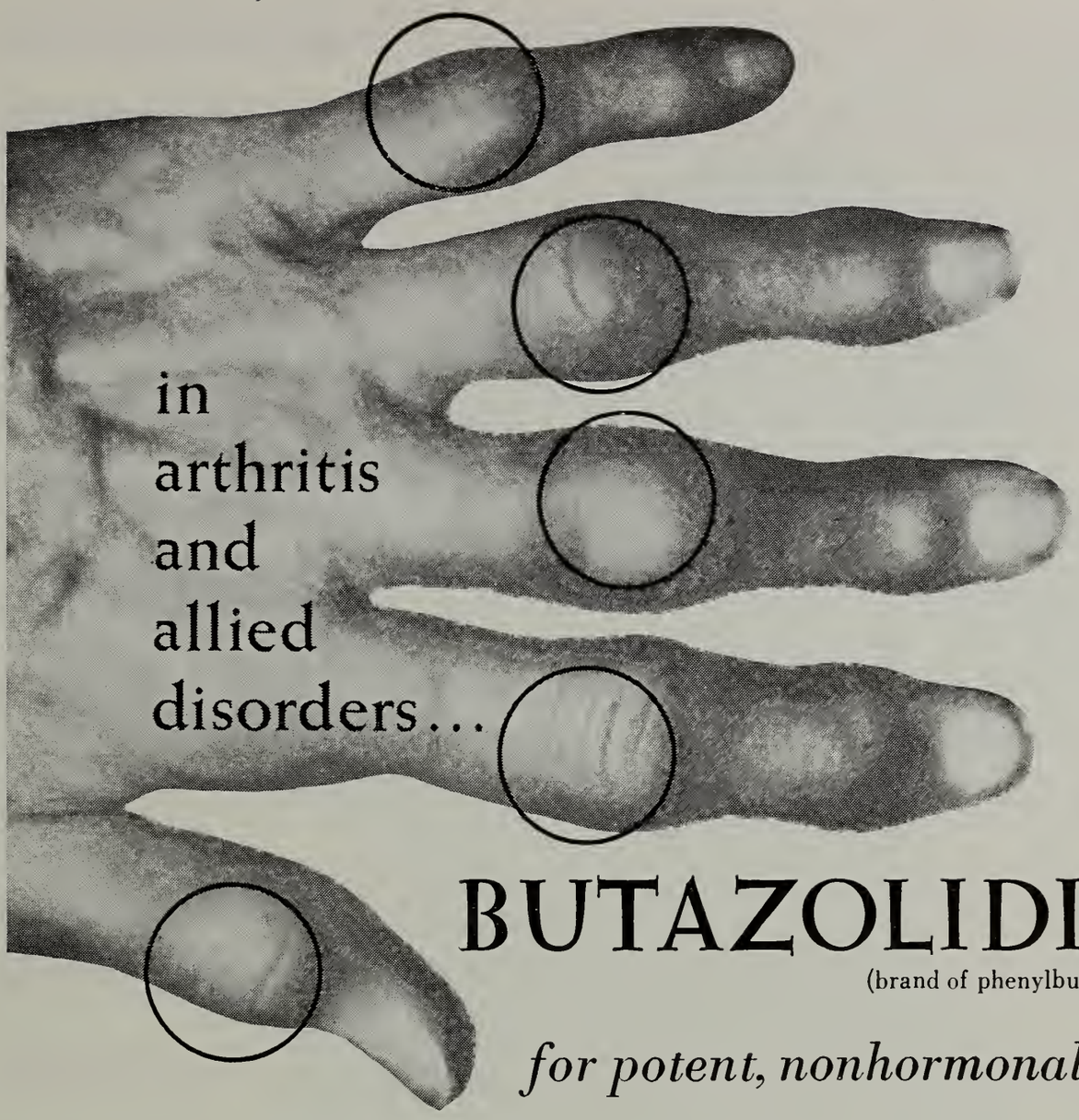
Other services contemplated include a news letter to parents to keep them advised of new information and national, state and local resources available. The news letter will carry contributions by parents and professional persons.

THE NEED

Workshops or institutes have been requested as a means of increasing knowledge and skills related to the care and adjustment of preschool blind children. When available resources or services prove insufficient to satisfactorily meet the needs of all preschool blind children, appropriate steps will be taken to improve or correct the situation.

There are 403 blind children under seven years of age in Ohio who are now registered in the office of the coordinator. Retrolental Fibroplasia appears most frequently as the reason for blindness. Counseling service is provided for 218 preschool blind children and their families through some local agency. Counseling service thru the coordinator's office is provided 185 children and their families. Consultant service to local workers is provided by the coordinator. Eight groups of parents now meet regularly in various sections of Ohio.

Doctors, nurses, teachers, caseworkers, parents and others will be consulted frequently to develop the kinds of services which will be most helpful.



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Detailed literature on request.

*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: Geriatrics 9:111 (Mar.) 1954.

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Addendum to Cincinnati Code on Medical Advertising

The Council of the Academy of Medicine of Cincinnati on July 20 after slight amendment, adopted recommendations of its Public Relations Subcommittee on Medical Advertising, and thereby further interpreted medical ethics in regard to advertising. The policy of the Cincinnati Academy was published in the July issue of *The Ohio State Medical Journal*, page 710. The following excerpt from the *Cincinnati Journal of Medicine* includes amendments and additions to those rules.

* * *

Resume of Proceedings of Council of the Academy of Medicine of Cincinnati, July 20, 1954. . . .

3. A report was submitted on a number of subjects by the Public Relations Subcommittee on Medical Advertising, in which the following recommendations were made:

(a) Signs used by clinical laboratories shall simply state the name of the clinical laboratory. The type of sign used shall follow the general rules for signs adopted for physicians;

(b) Under Special Notices, paragraph 1a, it was suggested that the word "Suburban" be omitted and substitute the words "three regular" in front of "daily." The ruling would then read "Notices shall be placed only in the three regular daily newspapers;

(c) Under Signs, paragraph 1, it was recommended that "The use of signs by the physician to make known his identity, location and specialty is proper and acceptable. These signs shall not designate any special type of equipment or procedure. They shall be dignified and conservative, both in design and color";

(d) That each special society be asked to submit a list of approved listings for physicians in their particular specialty for the classified section of the telephone directory;

(e) Clinics or groups may carry indefinitely the name of a retired or deceased physician, but the name alone of a retired or deceased physician may not be listed in the telephone directory for a period longer than one year after his retirement or death. (Council amended this recommendation by extending the time from one year after retirement or death to a period that would not exceed three editions of the telephone directory from the time of decease or retirement.)

(f) Revision of listing under "Hospitals" in classified section of telephone directory be revised as the present listing is misleading. It was requested that Council designate which institutions are to be listed as "Hospitals" and classify other medical establishments now listed under "Hospitals" according to their function, such as "Industrial Clinics," "Sanitoriums," "Dispensaries," etc. The executive secretary was instructed to obtain definitions of "Hospitals" from several sources, including the statutory definition as set forth in the revised code for the State of Ohio.

At ages 15 through 39 more men die from accidental injuries than from any other cause, according to Metropolitan Life. More than 40,000 accident fatalities each year occur among men under age 65.

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Rachel Hauschildt
637 West Ash Street

PORTSMOUTH
Wursters Drug Company, Inc.
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YOUNGSTOWN
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Strouss Hirshberg Company

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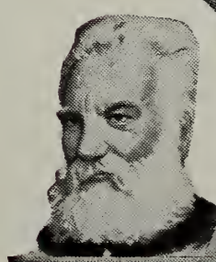
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Only a flawless pedigree — a long and illustrious ancestry of purebreds — can produce a champion show dog.

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Pedigreed in its field, **audivox** successor to Western Electric Hearing Aid Division, brings the boon of better hearing, and its enrichment of living, to thousands. With the magical modern transistor, with scientific hearing measurement and scientific instrument-fitting, serviced by a nation-wide network of professionally-skilled dealers, **audivox** moves forward today in a proud tradition.

TO THE DOCTOR: Send your patient with a hearing problem to a career Audivox and Micronic dealer, chosen for his interest, integrity and ability. There is such an Audivox dealer in every major city from coast to coast.



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The Pedigreed Hearing Aid

In Memoriam . . .

Robert Carothers, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1890; aged 90; died September 24; member of the Ohio State Medical Association through 1946; member of the Southern Surgical Association, the Clinical Orthopedic Society, the American Academy of Orthopedic Surgeons; Fellow of the American College of Surgeons, and diplomate of the American Board of Surgery; former president, Ohio State Medical Association.

Dr. Carothers was a three-fold leader in the medical profession. He achieved prominence as a physician and surgeon through a career which extended over 56 years; he was a leader in medical education in Cincinnati, and he devoted much time as a leading figure in organized medicine both on the local and state levels. Upon completion of his college training, Dr. Carothers interned at the Veterans' Hospital in Dayton, and went into practice in Newport, Ky. He moved to Cincinnati in 1900 and practiced there until his retirement in 1946.

Soon after going into practice he became the assistant to Dr. P. S. Connor, professor of surgery, in which capacity he served for 10 years. As such he was responsible for much of the teaching at the Medical College of Ohio. He became a member of the staff of Good Samaritan Hospital, later the Children's Hospital and was also on the staff of the Cincinnati General Hospital as senior surgeon in the Department of Orthopedics.

A past-president of the Academy of Medicine of Cincinnati, Dr. Carothers served on The Council of the Ohio State Medical Association from 1914 through 1920. He was then named President-Elect and for the term 1922-1923 served as President of the State Association. He also was active on a number of local and state committees.

He is survived by a daughter and a son, Dr. Ralph G. Carothers, also of Cincinnati.

Harry L. Babcock, M. D., Whitehouse; Ohio State University, 1898; aged 82; died September 24. Dr. Babcock began his practice in Findlay, moved to Waterville in 1904 and to Whitehouse in 1926. A veteran of World War I, during which he served as captain in the Medical Corps, he was a member of the American Legion. Surviving are his widow, and two sons.

Anson L. Brown, M. D., Columbus; Ohio State University College of Medicine, 1927; aged 61; died October 3; member of the Ohio State Medical Association and the American Medical Association. A practicing physician for many years in Columbus, Dr. Brown was operator of the Anson L. Brown, Inc., clinical laboratory. He was a member of the Community Church, the Athletic Club, the Ohio State University Faculty Club and Phi Rho Sigma. Survivors include his widow, his mother and two daughters.

George D. Cameron, Jr., Braceville; New York Homeopathic Medical College, 1930; aged 50; died September 28 as the result of a traffic accident. A resident of Braceville for about three years, Dr. Cameron previously practiced in Bedford and Solon and at the Ravenna Arsenal. He was scheduled to go into the Army Medical Corps as a lieutenant colonel on October 15. He is survived by his widow, his mother, three daughters and two sons. His father was the late Dr. George D. Cameron, Sr., who practiced for many years in Chagrin Falls.

Murat H. Cherrington, M. D., Logan; Ohio Medical University, Columbus, 1903; aged 77; died September 20; member of the Ohio State Medical Association; member of the American Medical Association; secretary-treasurer of the Hocking County Medical Society for many years and delegate of that Society to the State Association for numerous terms. Dr. Cherrington moved to Logan in 1905, two years after he received his medical degree. He received the 50-Year Pin from the State Association last year. In 1908, he and his late brother, Dr. Samuel Cherrington, opened the Cherrington Hospital in Logan, which became the Hocking County Hospital in 1946. He was a member of the Kiwanis Club and the Methodist Church. His widow survives.

Corliss Alton Day, M. D., Worthington; Ohio State University College of Medicine, 1947; aged 44; died September 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Day was a teacher in the public schools for a number of years before he went through medical school. After receiving his M. D. degree he practiced for about two years and then went into the Army Medical Corps. He returned to private practice in 1952. He was a member of several Masonic bodies including the Shrine, the Methodist Church and the Worthington Players Club. Surviving are his widow, a son, his mother and two sisters.

Paul DeCourcy, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1902; aged 76; died September 25; member of the Ohio State Medical Association. Dr. DeCourcy had practiced 52 years in Cincinnati and had been presented the 50-Year Pin of the Ohio State Medical Association. He and his three physician brothers belong to the fourth generation of physicians in the DeCourcy family. There are several physicians also in the fifth generation. Surviving are his widow,

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Personal communication (Apr. 12, 1950)

1951 Of 119 patients treated with Azulfidine prior to 1944, 90 patients (75%) were symptom-free or considerably improved when re-examined in 1949.

Svartz, N.: Acta. Med. Scandinav. 141:172, 1951.

1952 In a series of 52 patients with chronic ulcerative colitis 30, or 58%, showed significant improvement after treatment with Azulfidine.

Morrison, L. M.: Gastroenterology 21:133, 1952.

1953 *Morrison says:* "Azopyrine [Azulfidine] . . . has been effective in controlling the disease in approximately two-thirds of patients who had previously failed to respond to standard colitis therapy currently in use."

Morrison, L. M.: Rev. Gastroenterology 20:744 (Oct.) 1953.

literature available on request from:

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his brothers, Drs. Giles A., Joseph L. and Carroll DeCourcy; a sister, and a number of nieces and nephews.

John Crockett Easton, M.D., Springfield; Miami Medical College, Cincinnati, 1901; aged 80; died September 30; member of the Ohio State Medical Association through 1951; member of the American Academy of Ophthalmology and Otolaryngology. Dr. Easton served all of his professional career in Springfield and in 1951 was awarded the 50-Year Pin of the Ohio State Medical Association. Surviving are his two daughters, three brothers.

Frank Alfred Fritz, M. D., Barberton; Ohio State University College of Medicine, 1928; aged 54; died September 10; member of the Ohio State Medical Association. A native of Barberton, Dr. Fritz practiced there for 24 years. He served the school system as physician for two years, was Eagles physician for 20 years and Columbia-Southern Corporation physician for 20 years. He was a member of the Masonic Lodge. Surviving are his widow, a son and a daughter.

James A. Matson, M. D., San Diego, Calif.; Ohio State University College of Medicine, 1933; aged 46; died September 29. A native of Uhrichsville, Dr. Matson had practiced for a number of years in San Diego. He is survived by his widow, a son, a daughter, his parents and a brother, Dr. John W. Matson, of Los Angeles, also a graduate of O. S. U.

Charles E. Ream, M. D., Bowersville; Eclectic Medical College, Cincinnati, 1894; aged 87; died September 12; member of the Ohio State Medical Association through 1944; vice-president of the Greene County Medical Society in 1933 and its president the following year. Dr. Ream served all of his professional career in the Bowersville area, retiring from active practice in 1946. He was a recipient of the 50-Year Pin of the State Association. He was a 50-Year member of the Masonic Lodge, an honorary member of the Lions Club and a member of the Methodist Church. Survivors include two sons, one of whom is Dr. Arthur Ream, of Mechanicsburg.

Charles L. Ruggles, M. D., East Cleveland; Western Reserve University College of Medicine, 1913; aged 66; died September 29; member of the Ohio State Medical Association through 1952; fellow of the American Academy of Pediatrics. Dr. Ruggles was on the staffs of University, St. Luke's, City and Huron Road Hospitals as visiting pediatrician. For a quarter century he had been senior instructor in pediatrics at Western Reserve. Surviving are his widow; two sons, one of whom is Dr. Richard L. Ruggles; a brother and two sisters.

Henry B. Stotter, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1896; aged 80; died September 12; member of the Ohio State Medical Association through 1940. Dr. Stotter came to this country from Austria-Hungary in 1888. After completing his education, he practiced many years in Cleveland and received the 50-Year Pin of the State Association. He served in the Medical Corps during the Spanish-American War. He was a member of the Oakwood Country Club and belonged to the Temple. Survivors include a son, two brothers, and a sister.

George Stoskoph, M. D., Rockcreek Station; University of Wooster, Medical Department, Cleveland, 1892; aged 95; died on or about September 9. A former practicing physician in Cleveland, Dr. Stoskoph moved to Rockcreek Station about 15 years ago. Two half-sisters survive.

Warren E. Thomas, M. D., Milford; University of Cincinnati College of Medicine, 1930; aged 52; died September 14; member of the Ohio State Medical Association; member of the American Medical Association; vice-president of the Clermont County Medical Society and its president, 1942-1943; also active on a number of local committees. Dr. Thomas had served the Clermont County area for a quarter of a century. He was a member of the county board of health, a member of the Methodist Church and active in numerous community affairs. Survivors include his widow, a daughter, a sister and a brother, Dr. Edward R. Thomas, of Dayton.

William A. White, M. D., Canton; Eclectic Medical College, Cincinnati, 1897; aged 84; died September 25; member of the Ohio State Medical Association and member of the American Medical Association. Dr. White practiced for 11 years in Leipsic before moving to Canton in 1908. In 1947 he was given the 50-Year Pin of the Ohio State Medical Association. He was a 50-year member of the Masonic Lodge and a 50-year Knight Templar. He also was an elder in the Presbyterian Church, a member of the Chamber of Commerce and the Y. M. C. A. Survivors include his daughter and son, Dr. William A. White, Jr., also of Canton.

Andonius S. Zervos, M. D., Akron; medical degree from the National University of Athens, Greece, 1921; aged 58; died October 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Zervos practiced for a while in Wheeling, W. Va., and in Youngstown and moved to Akron 28 years ago. He was a 32nd Degree Mason, and belonged to the Greek Orthodox Church, Ahepa Lodge and the Greek-American Progressive Association. He is survived by his widow, two daughters, and three brothers, including Dr. Michael Zervos, of Youngstown.

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A.M.A. Miami Session . . .

Mid-Year Meeting, November 29 - December 2 Will Include Excellent Scientific Program, Exhibits and Meetings of House of Delegates

EASIER solution of medical problems that the family doctor encounters is the general aim of the American Medical Association's clinical meeting in Miami, Fla., November 29 through December 2.

More than 100 physicians will present scientific papers or participate in panel discussions during the meeting, directed toward alleviating the everyday medical problems of the physician.

The meetings in Miami's Dinner Key Auditorium and the McAllister Hotel are expected to be attended by more than 3,000 physicians from throughout the nation.

Information about Miami hotels and hotel reservation blanks appear in current issues of *The Journal of the A. M. A.*

Dr. Thomas G. Hull, Secretary of the A. M. A.'s Council on Scientific Assembly, said "we have attempted to arrange a program of broad general interest rather than one showing merely the results of investigation or experimentation. While various specialties are represented at the meeting, such as medicine, surgery and obstetrics, the program is not for the specialist in these fields, but rather for the general practitioner who also must work in these areas."

The lecture programs will include subjects of broad interest in medicine, surgery, pediatrics, neuropsychiatry, obstetrics and gynecology.

Outstanding medical authorities also will participate in the scientific exhibit where more than 80 displays will be presented.

Leading surgeons and obstetricians will be available at the scientific exhibit for conferences with individual doctors on problems in fractures and deliveries. Doctors are invited to bring x-rays of fracture cases they wish to discuss. The obstetrical section will include manikin demonstrations of deliveries.

Another section of the meeting, the technical exhibit, will have more than 130 drug, medical equipment and pharmaceutical manufacturers, food processors, medical book publishers and other commercial organizations participating.

SPECIAL FEATURES

Motion pictures will be shown continuously during the meeting and a special filming will be presented on Tuesday evening, November 30, in the McAllister Hotel. This will be the premiere showing of two outstanding films—"Lung Cancer: The Problems of Early Diagnosis," sponsored by the American Cancer Society, and "Differential Diagnosis of the Arthritides," by Dr. William B. Rawls, New York.

Closed-circuit color television again will be shown to doctors attending the clinical session through the sponsorship of Smith, Kline and French Laboratories. Programs originating from Miami's Jackson Memorial Hospital will be brought directly into the lecture hall.

The House of Delegates, the policy-making body of the A. M. A., will hold its sessions in the McAllister Hotel.

New York Dentists Start Prepayment Plan

Commenting editorially on the announcement by dentists of New York City of a plan to establish a voluntary prepaid dental care insurance plan, similar to Blue Shield medical care plans, the Columbus Dispatch made these pertinent observations:

"Another blow at the determined propagandists for socialized medicine is seen in the announcement in New York City of the first community-wide program for voluntary insurance against dental expense to be launched in this country.

"Under study for a number of years, the plan at the start will be available only to employe-groups of 40 or more persons in establishments where 75 per cent or more of those employed will contract for the service. If the undertaking prospers and wins wide acceptance, extension to other types of groups and to individuals is contemplated.

"The program provides for two classes of members, divided on a basis of annual income at the $5000-a-year level. Those at or below this figure receive full dental service at no expense other than the fixed premium stipulated in the contract. Those above the $5000 level are billed by the dentist at his usual rate and receive a sum stipulated for each service to apply on the total obligation.

"All participants are required to have a physical examination and have existing dental defects, up to a limit of $150, taken care of before the coverage takes effect.

"Some 8,000 dentists in the New York metropolitan area and in New Jersey have been invited to participate professionally. Those who accept will receive stipulated fees for various services to those insured under the plan.

This experiment will be watched with interest. Fundamentally it is no different from the many voluntary general health insurance plans now in operation and which are winning wide popularity.

"It represents another step toward recognition of the realities behind the specious clamor by special pleaders for federalized medicine and a constructive approach to the problem which preserves traditional American respect for free enterprise and individual liberties."

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

A Civil Service Commission breakdown of the separation of employees from federal jobs in the 13-month period ending last July 1 discloses 53 persons dismissed in the Department of Health, Education, and Welfare for suspected subversion. Another 131 employees of this department quit during the same period while their cases were under scrutiny. Of this group, an undetermined number quit without knowing that their loyalty and character were being questioned. In all federal agencies 1,743 employees were dismissed for subversion.

* * *

Recently appointed to the Advisory Council on Health (general) of the National Institutes of Health was Dr. Thomas Hale Ham of Cleveland.

* * *

Physicians who are nationals of Germany and have been admitted to this country for permanent residence must now register under the Doctor Draft Act. Selective Service announced that this requirement applies to those who had not yet reached their 50th birthday on January 15, 1951. The action stems from the expiration of a provision in a pre-World War II U. S.-Germany treaty exempting nationals of each country from military service while living in the other country.

* * *

Dr. Howard A. Rusk is new president of the International Society for the welfare of cripples. . . . Dr. Merlin L. Trumbull is president of the American Association of Blood Banks. Dr. James J. Griffitts is president-elect.

* * *

Almost 400,000 nurses are now at work in the United States, an increase of 16,000 in five years, according to a Public Health Service estimate. The breakdown indicates that there are 231,000 hospital nurses; 74,000 private duty nurses; 35,200 nurses working in physicians' offices; 25,300 public health nurses; 14,000 industrial nurses; 8,200 nurse educators and 1,900 miscellaneous.

* * *

Dr. Theodore G. Klumpp, president of Winthrop-Stearns, Inc., and recently-appointed chairman of the Hoover Commission's Medical Services Task Force, has been named to a commission committee to study depot utilization. The committee will review the policies and procedures of government agencies in the establishment, location, operation, and consolidation of storage facilities, including those for hospital supplies.

Some of the drugs scheduled for the consideration of the Second Annual Symposium on Antibiotics, held in Washington, D. C., October 25, included tetracycline, etamycin, spiramycine, pleomycin, anisomycin, PA-105, actinomycin C, and fungichromin.

* * *

As of September 1, Veterans Administration had only two service-connected cases awaiting hospitalization. At the same time 19,878 non-service cases had qualified for treatment and were awaiting hospitalization. For August the daily patient load was 109,450, compared with 105,486 in August, 1953.

* * *

Although total federal spending for scientific research shows a 10 per cent decrease this year, under last, approximately two per cent more will be spent for medical research, according to a National Science Foundation estimate.

It is estimated that 20 federal agencies will spend about $2 billion for all forms of scientific research during the present fiscal year. Of this, about 87 cents of each research dollar is obligated for the physical sciences, 11 cents for the life sciences and two cents for the social sciences.

* * *

Dr. Maurice Levine, Cincinnati, has been appointed to represent the National Institute for Mental Health on an inter-council committee of the United States Public Health Service. He is a member of the national advisory council to the institute.

* * *

According to Dr. John C. Bugher, director of the Atomic Energy Commission's Division of Biology and Medicine, "repeated small transfusions from different donors may create more hazard than from the original radiation exposure," because of such complications as incompatability and infectious hepatitis. He recommends a conservative approach to transfusions for radiation exposure, "save in a position of utmost emergency."

* * *

Both the American Association of Blood Banks and the American Society of Clinical Pathologists have given "approval in principle" to a plan to establish a nationwide blood-collecting, storing, and distributing system, based on the clearing

(Continued on page 1094)

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house plan used by banks to exchange funds and credits. The proposed "National Blood Foundation" also has the approval of the American Medical Association.

* * *

It has been reported that during a recent meeting in Chicago representatives of government medical services were "all but asked to show cause why intern training in Army, Navy, Public Health Service, and veterans hospitals should not be abolished," in order to relieve shortages in non-federal institutions. As of the first of this year, government hospitals had 521 interns on duty, six per cent of the total supply. The occasion was a hearing conducted by the American Medical Association Ad Hoc Committee on Internship.

* * *

As of September 30 Hill-Burton hospital projects approved since the program's inception in 1946 totaled 2,336, of which 1,709 are in operation. In stages of construction are 527; initially approved, 100. Total estimated cost is about $1.9 billion, of which the federal share is almost a third. This year's program contemplates the simulation of construction of other than complete hospitals in areas of small population.

* * *

Ruling of Internal Revenue Service indicates that where a university student pays a lump sum fee covering tuition and other expenses, and no breakdown is given as to the size of the prepaid medical fee, no part of the sum is deductible as a medical expense for tax purposes. If itemized or readily obtainable from the university it may be considered as an item for deduction under heading of medical expenses.

* * *

According to a recent survey disabled veterans rehabilitated under a special Veterans Administration program have more than doubled their pre-war incomes. The special training is restricted to service-connected cases where the disability has or could seriously interfere with the veteran's employment in his established occupation. Disabilities involved in the survey included: orthopedic, 41 per cent; nervous or mental, 24 per cent; circulatory and heart 7 per cent; and tuberculosis or other respiratory, 8 per cent.

* * *

Federal Trade Commission has issued a consent order which curbs advertising representations of Washington Institute of Practical Nursing, Seattle. The operator is ordered to drop "Institute" from the name of his business and to make no claims that a correspondence course is capable of qualifying individuals for state examinations for registered or licensed practical nurses or for such positions in hospitals or doctors' offices.

Billroth Surgical Association To Meet in Cleveland

The Billroth Surgical Association, Inc., is offering its fall postgraduate assembly in the large lecture room of the Cleveland Health Museum, 8917 Euclid Avenue, Cleveland, and the Tudor Arms Hotel, on Wednesday, November 10. The program has been announced as follows:

2:00 p. m.—Motion picture, "Operative Cholangiography."

2:30—"Review of 400 Operations in Ingrown Toenails with a Description of a New Operative Technique," Dr. Clyde Cranston, Wakeman, former Lieutenant Colonel, U. S. Army.

3:00—"Origin of Adenomatous Goiter," Dr. Benjamin S. Kline, director of pathology, Woman's Hospital, Cleveland.

3:30—"Review of Cholangiography at Woman's Hospital," Dr. Roy Thompson, Roentgenology Department, Woman's Hospital.

4:00—"Gastrojejunostomy (A New Anatomical Approach to an Old Operative Procedure)," Dr. I. H. Einsel, visiting surgeon, Woman's Hospital.

6:30—Banquet, Tudor Arms Hotel, $5 a plate.

7:30—"Changing Picture of Thyroid Disease," Dr. Robert Dinsmore, director of surgery, Cleveland Clinic.

Reservations or applications for membership in the society should be sent to J. J. Evans, M. D., secretary, 5504 Superior Avenue, HEnderson 1-4731; or the treasurer, Peter Coppedge, M. D., 10300 Carnegie Avenue, GArfield 1-3740.

Northwestern Ohio Physicians Elect Officers at 110th Meeting

Another successful session was put on record by the Northwestern Ohio Medical Association with the 110th meeting held in Tiffin on October 6.

Dr. Henry L. Abbott, Tiffin, retiring president, presided at the meeting.

The election of officers was as follows: Dr. Boyd Travis, Bluffton, formerly vice-president, was named president; Dr. Henry B. Larzelere, Toledo, former secretary, was elected vice-president; Dr. F. A. McCammon, Van Wert, former treasurer, was elected secretary; and Dr. Thomas D. Efstation, Tiffin, was named treasurer.

The address of welcome was given by Dr. Walter A. Daniel, president of the host Seneca County Medical Society. Speakers for the scientific program were Dr. Joseph Ewing, Akron; Dr. Lawrence M. Weinberger, Akron; Dr. Paul S. Rhoads, Chicago, and Dr. D. Frank Kaltreider, Baltimore, Md.

Brief remarks were given by Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District. Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, spoke at the luncheon session on "News from Our Headquarters in Columbus."

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Coordinated Distribution of Gamma Globulin To Be Discontinued

The program under which the Office of Defense Mobilization has coordinated the distribution of gamma globulin during the past two years will continue through the end of 1954, but not beyond. This announcement was made by Arthur S. Flemming, director of the Office of Defense Mobilization.

He said that for the balance of this year, commitments which have been made to the state and territorial departments of health will be fulfilled as required for use in measles, infectious hepatitis and poliomyelitis from the stocks of gamma globulin provided for this purpose by the National Foundation for Infantile Paralysis and the American National Red Cross.

According to the O. D. M. Health Resources Advisory Committee, an increase in supply has taken place during the two-year period since the program started to a point where all foreseeable demands can be met. Originally the program was undertaken to permit an equitable distribution of the limited supply.

From the start of the program through September 16, the U. S. Public Health Service reported the National Foundation for Infantile Paralysis and the Red Cross have contributed in approximately equal amounts a total of more than 20 million cc. of gamma globulin. A portion of the material furnished by the National Foundation consisted of g. g. sold to the Foundation by pharmaceutical manufacturers. It was further revealed that contracts for the further purchase of such material by the Foundation have been terminated as of October 1.

"As this was a voluntary program on the part of the producers and inasmuch as the contracts have been cancelled," the U. S. Public Health Service informed state health departments, "there is no legal restriction on the sale on the domestic market of gamma globulin which might be produced subsequent to the completion of these contracts."

At least one national pharmaceutical manufacturer has announced that it is now releasing gamma globulin commercially to medical and drug channels. One company states that the product is available in a 2 cc. vial retailing for $7.08, and in a 10 cc. vial retailing for $33.33.

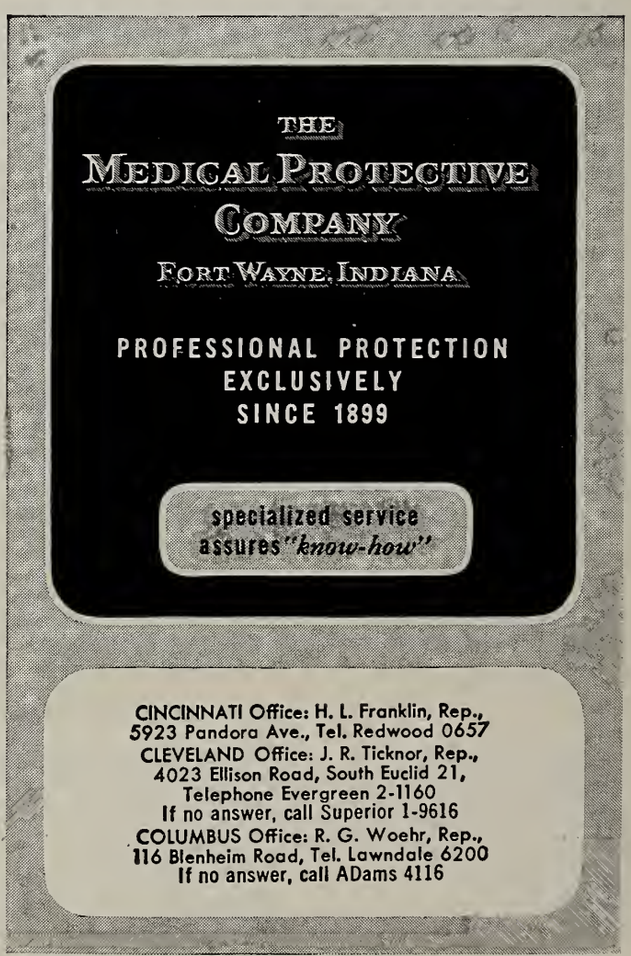
The Ohio Department of Health will continue to distribute gamma globulin for measles, infectious hepatitis and poliomyelitis in keeping with the existing cooperative program through December 31, 1954, Dr. Martin D. Keller, of the Division of Communicable Diseases, Ohio Department of Health, reported for *The Journal*. The Department is keeping in close touch with national developments and will determine a policy to be followed in Ohio as quickly as possible, he said.

Dr. Ralph E. Dwork, acting director of the Ohio Department of Health, discussed this subject only briefly before the recent annual conference of Ohio health commissioners. He urged that gamma globulin not be used for poliomyelitis cases in Ohio's two counties where the Salk vaccine is being tested, that is Montgomery and Richland Counties. "We stand to invalidate a year of scientific effort by premature release of a product whose own value is doubtful," he said. It is to be remembered that it is excellent when dealing with measles and hepatitis," he further stated.

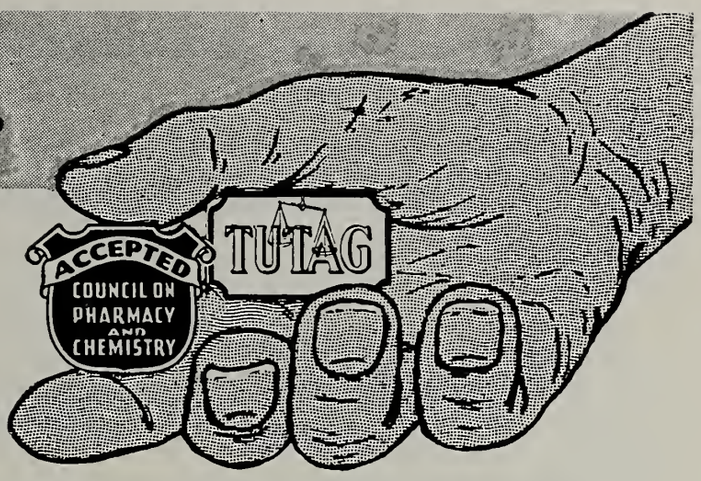
Editor's Note: As this issue of *The Journal* was going to press, it was announced publicly that the National Foundation for Infantile Paralysis has contracted to purchase enough of the Salk polio vaccine to treat nine million children and expectant mothers next year. Foundation President Basil O'Connor, in announcing the transaction, said: "The National Foundation is taking a calculated financial risk in purchasing vaccine before it has been found to be effective."

Evaluation of this year's extensive tests with the Salk vaccine will not be announced until about April 1, 1955. Study is going on at the University of Michigan for this purpose.

The Cleveland Health Museum's Elisabeth Severance Prentiss National Award in Health Education this year went to Ira Vaughan Hiscock, Sc. D., chairman of public health at Yale University.



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F. T. C. Accuses 17 Insurance Firms Of False Advertising

The following report of action by the Federal Trade Commission against 17 insurance companies (a number of which do business in Ohio) was released from Washington, D. C., by the *Associated Press* on October 19:

* * *

The Federal Trade Commission today accused 17 companies in the health, hospital and accident insurance business of "false and misleading advertising."

Together, the 17 firms—including the four largest in the field—represent annual premium payments of more than 300 million dollars, or about one-third of the total health and accident policies written on individuals in the country.

Among those named in the FTC complaint—which grew out of a 10-month nationwide investigation—were the Bankers Life and Casualty Co. of Chicago (the White Cross), Mutual Benefit Health and Accident Association of Omaha (Mutual of Omaha), Reserve Life Insurance Co. of Dallas, and United Insurance Co. of Chicago.

Each firm was charged with from three to five allegedly deceptive practices. Each was allowed 20 days to file replies. Individual hearings are to be held in December.

If, after these hearings, the FTC finds there is basis for the charges, it may issue orders forbidding these practices in the future.

FTC Chairman Edward F. Howrey said the action is aimed at false or deceptive advertising claims concerning the extent of insurance protection and benefits payable.

Howrey said in a statement this first broad inquiry of its kind grew out of "a flood of letters" sent by policy holders who he said complained the insurance coverage they received was not the same as advertised.

The FTC complaints attacked the following alleged misrepresentations:

1. Policy termination. A typical advertising claim, it was charged, talks about "no automatic termination age . . . You and your family are covered from 1 to 75." Actually, FTC said, most policies are renewable only at option of the company and can be cancelled at the end of any term for any reason.

2. Extent of coverage. FTC said that, whereas benefits are advertised "for each sickness or accident," many policies pay nothing for losses due to nervous disorders, venereal disease, childbirth, dental operations and so on.

3. Maximum dollar limits. Advertising claims of "up to $525 for each surgical operation" are deceptive in many cases, said FTC, because the full amount is payable for only one or two relatively rare operations.

4. Starting time of coverage. Although some companies represent insurance as being effective

For twenty years . . .
we have constantly endeavored to serve
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better products for better birth control

Cooper Creme

no finer name in contraceptives



active ingredients:
Trioxymethylene .04%
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Whittaker Laboratories, Inc.
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FREE

Please send: Full Size $1.50 Combination Package Free—Cooper Creme/Dosimeter.

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11

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Plan now to give yourself a holiday soon. You'll *like* Dearborn Inn, doctor! Advance reservations are advisable.

DEARBORN INN
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THE ANN ARBOR SCHOOL

. . . is a private school for children from six to fourteen, of average or superior intelligence, with emotional or behavior problems.

. . . providing intensive individual psychotherapy in a residential setting.

A. H. KAMBLY, M. D.
Director

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Ann Arbor, Michigan



THE MARY POGUE SCHOOL

Complete facilities for training Retarded and Epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision of skilled personnel.

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Medical Director
BARCLAY J. MacGREGOR
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RATIONAL METHODS OF TREATMENT

(Member of American Hospital Association; Ohio Hospital Association and National Association of Private Psychiatric Hospitals)

W. W. DANGELEISEN, M.D., *Medical Director*

when issued, FTC said, coverage for many sicknesses is delayed until the policy has been in effect for a time—such as six months for tuberculosis or heart disease.

5. **Health** status of the insured. FTC charged many companies state they do not require medical examinations, but fail to say the policy does not cover any loss traceable to a condition which existed when the policy was issued.

6. **Sale** of a plan. Some companies imply, FTC said, that many benefits are obtainable from purchase of a single policy for a few cents a day, when actually several policies are required to get all the advertised benefits.

7. **Some** advertisements offer regularly monthly income "even for life," FTC charged, but only in cases of total disability due to accidental bodily injury are life-time payments made.

One firm—The Life Insurance Co. of America and its officers—are charged with falsely representing that it is an old, established, reliable life insurance company and a pioneer in the accident and health field.

The corporation is less than two years old, FTC said, and its volume of life insurance is "insignificant." A hearing in this case will be held in Wilmington, Del., on Dec. 21.

The hearing schedules for the other firms, all in home office cities:

American Hospital and Life Insurance Co., Dec. 20, San Antonio, Tex.

American Life and Accident Insurance Co., Dec. 14, St. Louis.

Automobile Owners Safety Insurance Co., Dec. 13, Kansas City.

Bankers Life and Casualty Co., Dec. 15. Chicago.

Commercial Travelers Insurance Co., Dec. 17, Salt Lake City.

The Commercial Travelers Mutual Accident Assn. of America, Dec. 20, Utica, N.Y.

Guarantee Reserve Life Insurance Co. of Hammond, Ind., and its officers, Dec. 8 at Hammond.

Guarantee Trust Life Insurance Co., Dec. 13, Chicago.

Illinois Commercial Men's Assn., Dec. 10, Chicago.

La Salle Casualty Co., Dec. 14, Chicago.

Mutual Benefit Health and Accident Assn., Dec. 16, Omaha.

Prudence Life Insurance Co., Dec. 9, Chicago.

Reserve Life Insurance Co., Dec. 17, Dallas.

Southern National Insurance Co., Dec. 15, Little Rock, Ark.

Travelers Health Assn., Dec. 15, Omaha.

United Insurance Co., Dec. 16, Chicago.

* * *

Editor's Note: The Council of the Ohio State Medical Association, at its meeting on September 18-19, directed *The Journal* to cancel a contract for advertising with the United Insurance Company. The action was taken following complaints from members of the Association.

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

SURGERY—Surgical Technic, two weeks, Nov. 8, Nov. 29. Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, March 7, 1955. Surgical Anatomy & Clinical Surgery, two weeks, March 21, 1955. Surgery of Colon & Rectum, one week, Nov. 29. General Surgery, two weeks, Dec. 6. Clinical Fractures, two weeks, by appointment.

GYNECOLOGY—Vaginal Approach to Pelvic Surgery, one week, Nov. 1. Office & Operative Gynecology, two weeks, Feb. 14, 1955.

OBSTETRICS—General & Surgical Obstetrics, two weeks, Nov. 1.

MEDICINE—Gastroscopy & Gastroenterology, two weeks, Nov. 1.

RADIOLOGY—Clinical Diagnostic Course, two weeks, by appointment.

PEDIATRICS—Clinical Course, two weeks, by appointment.

DERMATOLOGY—Clinical Course, two weeks, by appointment.

CYSTOSCOPY—Ten-Day Practical Course, every two weeks by appointment.

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Three Prescription Departments

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broad-spectrum antibiotic

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Brand of **tetracycline**

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Tetracyn is supplied in such convenient dosage forms as Capsules, Tablets and Oral Suspension (chocolate flavored).

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For well-tolerated therapy of such common infections as:

Pneumococcal infections, including pneumonia, with or without bacteremia; streptococcal infections, with or without bacteremia, including follicular tonsillitis, septic sore throat, scarlet fever, pharyngitis, cellulitis, urinary tract infections due to susceptible organisms, and meningitis; many staphylococcal infections, with or without bacteremia, including furunculosis, septicemia, abscesses, impetigo, acute otitis media, ophthalmic infections, susceptible urinary tract infections, bronchopulmonary infections, acute bronchitis, pharyngitis, laryngotracheitis, tracheobronchitis, sinusitis, tonsillitis, otitis media, and osteomyelitis; certain mixed bacterial infections; soft tissue infections due to susceptible organisms.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D., MIDDLETOWN)

CLERMONT

The Clermont County Medical Society met in the Millcroft Inn, Milford, on October 20. Guest speaker was Dr. Nelson R. Cragg, Cincinnati, whose subject was "Errors in ENT Diagnosis."

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

CLARK

The Clark County Medical Society met September 20, 1954, at the Shawnee Hotel in Springfield, Ohio.

The scientific program consisted of a panel discussion by Drs. Burrell, Horton, and Davidson. Their subject was "Hematuria."

Following this, a motion picture entitled "Advances in Control of Cancer of the Colon and Rectum" was presented.—E. H. Winterhoff, M. D., Secretary.

GREENE

The business and scientific meeting of the Greene County Medical Society was held on September 9 at the Greene Memorial Hospital, Xenia.

Dr. Gordon E. Savage, health commissioner, presented a complete report of how the proposed Health Tax Levy money was to be used and requested that the Society go on record as approving the levy. Following his talk members present voted to endorse the proposed taxation.

It was agreed that temporary arrangements be made to cover the service in the local cancer clinic until a policy is arrived at by the Committee and the Society.

The report of the Library Committee was complete. Following discussion, $150 was placed at the disposal of the committee for additional publications and to modernize the library over a period of time.

Guest speaker for the occasion was Dr. Robert C. Austin, Dayton, who spoke on "Physiological Concept in the Management of Thyroid Disease."—Information from H. R. Tharp, M. D., Secretary.

MIAMI

Dr. Robert Austin, Dayton, was speaker for the October 8 meeting of the Miami County Medical Society in Piqua, where he spoke on the topic, "Physiological Concepts in Management of Thyroid Diseases."

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

The Lima and Allen County Academy of Medicine held a dinner meeting at the Shawnee Country Club, Lima, on September 21, and had as guest speaker, Dr. William J. Engel, Department of Urology, Cleveland Clinic. He spoke on the subject, "Congenital Anomalies of the Urinary Tract To Be Considered in General Diagnosis."

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

ASHTABULA

Physicians of the area joined the Chamber of Commerce of Orwell on October 5 to honor Dr. John H. Ross for 50 years of faithful service to his community. He has been in Orwell since 1921 and has practiced since 1904.

Highlights of the occasion were presentations to Dr. Ross of an engraved trophy by the Chamber of Commerce, a painting by his daughter, Mrs. E. E. Ellies, and his favorite stethoscope, gold-plated and engraved by his son, Dr. William Ross.

CUYAHOGA

"The Early Recognition and Treatment of Cancer" was the theme of the October 15 meeting of the Academy of Medicine of Cleveland in the Medical Library Auditorium.

The portion of the program preceding dinner was in the form of a panel discussion by four physicians whose fields of discussion were: Dr. John H. Lazzari, "Cancer of the Breast"; Dr. George W. Crile, Jr., "Cancer of the Thyroid"; Dr. James W. Reagan, "Cancer in Situ"; Dr. Herbert H. Johnson, "Cancer of the Skin."

Following the social period and dinner, the subject, "Rational Cancer Chemotherapy," was discussed by Dr. Cornelius P. Rhoads, scientific director of Memorial Center for Cancer and Allied Diseases and professor of pathology, Sloan Kettering Division of Cornell University Medical College.

The program was coordinated with a postgraduate meeting on "Management of Advanced Malignancy," at St. Luke's Hospital, scheduled for November 4-5.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

Dr. Edwin H. Ellison, Columbus, associate professor of surgery, Ohio State University, was guest speaker at the September 21 meeting of the Mahoning County Medical Society in Youngstown. He spoke before the evening meeting in the Elks Club on the subject, "Cancer of the Colon."

In the afternoon at South Side Hospital, Dr. Ellison addressed members of the Society and

for greater safety in streptomycin therapy...

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Streptomycin and dihydrostreptomycin in equal parts

Distrycin has an important advantage over streptomycin. It has the same therapeutic effect but ototoxicity is greatly delayed. Since the patient is given only half as much of each form of streptomycin as he would have on a comparable regimen of either one prescribed separately, the danger of vestibular damage (from streptomycin) or cochlear damage (from dihydrostreptomycin) is significantly lessened.

Signs of vestibular damage appear in cats treated with Distrycin as much as 100 per cent later than in animals given the same amount of streptomycin.



Cat treated with streptomycin shows no nystagmus after whirling.



Cat given the same amount of Distrycin has normal reflex.

On dosage of 1 Gm. per day for 120 days, ototoxicity was as follows*:

	Vestibular damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	12	6	18
Dihydrostreptomycin	6	0	6
Distrycin	0	0	0

	Cochlear damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	0	0	0
Dihydrostreptomycin	12	3	15
Distrycin	0	0	0

**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

Distrycin dosage is the same as for streptomycin. In tuberculosis the routine dose is 1 Gm. twice weekly, in conjunction with daily para-aminosalicylic acid or Nydrazid (isoniazid). In the more serious forms of tuberculosis, Distrycin may be given daily, at least until the infection has been brought under control.

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residents and interns of both hospitals on the subject, "Current Research."

The program for the October 19 meeting of the Society was in the form of a panel discussion on the subject, "Cancer Project in Youngstown." Taking part in this discussion were Drs. R. J. Scheetz, A. J. Quinn and A. E. Rappoport.

SUMMIT

Dr. Robert B. Chamberlin, Twinsburg, was honored at a dinner meeting by his colleagues for completion of 50 years of service in the medical profession in the Portage Country Club, September 17. The all-day outing at the club was climaxed by a dinner.

Dr. C. A. Gustafson, Youngstown, Councilor of the Sixth District, presented Dr. Chamberlin the 50-Year Pin on behalf of the Ohio State Medical Association.

The Society honored Dr. A. S. McCormick "for his forty-three years of faithful service" to the medical profession at a special meeting on September 15.

Dr. McCormick was secretary of the Society for many years and treasurer also for many years. He founded *The Bulletin* of the Society and served as its editor for numerous terms. He is at present historian for the Society, a post which he has held since 1942 and in some previous years.

In 1926 Dr. McCormick organized the Doctors' Orchestra which he still directs and which gives numerous concerts each year.

The special program issued for the meeting lists numerous other activities and accomplishments of Dr. McCormick.

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, was the headline speaker for the October 5 meeting. His subject was "The Leukemias." A dinner honoring Dr. Doan was given at the Akron City Club preceding the meeting.

TRUMBULL

The Trumbull County Medical Society and Auxiliary held a joint dinner at the Warner Hotel, Warren, on September 15. Speaker for the medical meeting following was Dr. Stanley T. Garber, professor of obstetrics at the University of Cincinnati College of Medicine, who spoke on "Toxemias in Pregnancy." The ladies held a separate business meeting.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

TUSCARAWAS

Members of the Tuscarawas County Dental and Pharmaceutical Associations were guests at the September 9 meeting of the Tuscarawas County Medical Society.

William S. Hewett, of the firm of Merrill, Lynch, Pierce, Fenner and Beane, gave an interesting talk on "Securities and Investments." He emphasized the necessity for invested capital to keep our high standards of living and pointed out that in the average industry today there is an investment of $17,000 for each employee. He discussed also the various types of investments.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

"Massive Pulmonary Hemorrhage" was the topic discussed by Dr. Scovell Hopkins, Huntington, W. Va., at the October 11 meeting of the Scioto County Medical Society in Portsmouth.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The subject, "Diagnostic Clues in Medical Practice" was discussed by Dr. Isidore Snapper, director of medical education, Beth-El Hospital, Brooklyn, N. Y., at the September 20 meeting of the Columbus Academy of Medicine.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

ASHLAND

The *Cleveland News* devoted more than 24 column-inches to a feature story on a community fete for Dr. G. B. Fuller, of Loudonville, on October 6. The article by C. Allen Knight, of the *Cleveland News*, in part reads as follows:

"Just about every resident in this Ashland County town of 3,000 gathered in Main St., last night to honor Dr. Gaillard B. Fuller, and the silver-haired country doctor rewarded them with the surprise announcement that Loudonville is about to get a hospital, its first.

"The plan for a community-owned hospital had been the doctor's secret for eight years. He revealed that home town money for a $350,000 institution is 'in the till' and that construction will start next spring.

"The announcement climaxed 'Doc Fuller Day' as hundreds gave Doc an ovation for his 50 years of practice in this community."

LORAIN

The regular monthly meeting of the Lorain County Medical Society was held on October 12 at the Spring Valley Country Club, Elyria, beginning with a dinner. Following the business meeting, an address was given by Dr. Robert W. Schneider, Cleveland, on the subject, "The Use of Radioactive Iodine (I-151) in the Diagnosis and Treatment of Thyroid Diseases."

RICHLAND

The Richland County Bar Association entertained the Richland County Medical Society at a joint meeting October 14, at the Westbrook

Country Club, Mansfield, Ohio, to hear an address by Mr. Edward F. Willenborg, Executive Secretary of the Academy of Medicine of Cincinnati, on medico-legal problems of the day. The meeting was attended by nearly two hundred members of the medical-legal associations.

Action for better understanding of common problems and adoption of standards of practice are in the process of clarification. Final action by the Medical Society and the Bar Association is expected to be consumated in the very near future. An enjoyable dinner was served.—Russell H. Barnes, M. D., President.

Pioneer of Cleveland Area Blue Cross Dies

John A. McNamara, pioneer in establishment of the Cleveland Hospital Service Association (Blue Cross) and its head for a number of years, died on September 12 in West Palm Beach, Florida.

Mr. McNamara went to Cleveland to organize the plan from Chicago where he was editor of *Modern Hospital.* After 14 years as director, he retired and moved to Florida, where he served as a consultant in establishing hospital service organizations.

Activities of Woman's Auxiliary . . .

By MRS. FREDERICK W. JAMES, Chairman, Publicity Committee, 423 E. Allen St., Lancaster, Ohio

President—Mrs. A. Paul Hancuff, 3551 Maxwell Rd., Toledo, Ohio

President-Elect—Mrs. Karl Ritter, 1420 Shawnee Rd., Lima, Ohio

Vice-President—Mrs. Charles Obert, 20710 Park Cliff Drive, Fairview Park, Cleveland 26, Ohio

Recording Secretary—Mrs. S. L. Meltzer, 2442 Dorman Dr., Portsmouth, Ohio

Corresponding Secretary—Mrs. John Dickie, 2146 Shenandoah Rd., Toledo, Ohio

Treasurer—Mrs. Herbert Van Epps, 435 E. 15th St., Dover, Ohio

Past President—Mrs. N. M. Reiff, 404 Rawlings St., Washington Court House, Ohio

FALL CONFERENCE

The Woman's Auxiliary to the Ohio State Medical Association held their Fall Conference, September 20 and 21 at the Southern Hotel in Columbus. Mrs. A. Paul Hancuff, president, conducted the Board meeting Monday afternoon and evening.

During the General Assembly meeting Tuesday morning, reports were given by the state chairmen. Mrs. Karl F. Ritter, president-elect, explained the "Plan of Workshop" and the members broke up into small groups for discussion of current problems. Luncheon was served with the Woman's Auxiliary of the Columbus Academy of Medicine in charge of arrangements. Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, and Mr. George Saville, director of public relations for the State Association, were guests and gave talks following the luncheon.

CHAMPAIGN

The Woman's Auxiliary to the Champaign County Medical Society met for luncheon in Millner's Colonial Room. During this first meeting of the year the new president, Mrs. I. Miller presided. Plans for the year were discussed.

The Auxiliary and the Champaign County Medical Society recently held a dinner meeting at the Urbana Country Club. Mrs. A. Paul Hancuff, State President, was the guest of honor.

CLARK

Mrs. A. Richard Kent, president of the Woman's Auxiliary to the Clark County Medical Society, entertained the group at a breakfast in her home at 20 Brighton Rd. Assisting Mrs. Kent with activities of the Auxiliary this year will be: Mrs. C. F. Parker, president-elect; Mrs. J. F. Doyle, vice-president; Mrs. W. B. Williamson, recording secretary; Mrs. F. C. Link, corresponding secretary; and Mrs. H. V. Allen, treasurer.

Two major projects have been chosen for the new season: The nurses' scholarship fund, which is financed by the gardenia sale held in the spring; and transportation of children with cerebral palsy to and from their classes at Springfield City Hospital three days each week.

CLINTON

Trebein Manor, Xenia, was the scene of a delightful luncheon, September 14, when members of the Woman's Auxiliary to the Clinton County Medical Society were guests of the Greene County Woman's Auxiliary. Representatives from Fayette County Auxiliary were also guests. Mrs. A. Paul Hancuff of Toledo, was the principal speaker. Preceding the luncheon the Clinton County Auxiliary held a short business meeting with the president, Mrs. Arthur Lippert, presiding.

COSHOCTON

Mrs. J. C. Briner was the hostess September 14 to members of the Woman's Auxiliary. Mrs. G. A. Foster and Mrs. F. W. Craig gave the highlights of their trip to the A. M. A. Convention at San Francisco. Plans were made to entertain the seventh district on October 15 at the Coshocton Country Club.

ERIE

Mrs. D. R. Lehrer, president, conducted the first fall meeting of the Woman's Auxiliary to the Erie County Medical Society. A luncheon at the Business Women's Club preceded the afternoon program and business session. Mrs.

A. Paul Hancuff was guest speaker. Hostesses were Mrs. H. T. Kesinger, Mrs. R. F. Hoffman, Mrs. William Seiler and Mrs. Edward Baxter.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society held its first meeting of the new year at Colonial Courts on September 14. Mrs. C. H. Hamilton, Mrs. F. A. Dowdy and Mrs. R. S. Bode were hostesses. The president, Mrs. A. B. VanGundy conducted the business meeting.

A party was given September 27 at the Nurses' Home to welcome the new class of student nurses. Mrs. Fred Spangler was in charge, assisted by Mrs. F. Dowdy, Mrs. J. L. Kraker, Mrs. G. Gardner and Mrs. F. James.

GUERNSEY

Mrs. George F. Swan, president of the Woman's Auxiliary to the Guernsey County Medical Society, was the hostess at a luncheon in her home for the first meeting of the season.

The Auxiliary has a number of philanthropic projects, including recruitment and financial assistance of student nurses, health education, and assistance with other health organizations in the county. A number of members also assist in the operation of the Snack Bar at the Guernsey Memorial Hospital. At the next meeting the group will sew for the Cancer Society.

HURON

A dessert luncheon was enjoyed by the members of The Woman's Auxiliary to the Huron County Medical Society, at the home of Mrs. A. H. Kimmel in Norwalk. The delegate to the National Convention, Mrs. T. H. Smith, gave an excellent report and delighted her viewers with beautiful pictures of the trip.

OTTAWA

The September meeting of the Woman's Auxiliary to the Ottawa County Medical Society was held in the home of Mrs. Jack Witker. Plans were made for the annual October rummage sale. The Doctors joined their wives for a social hour after their meeting held on the same evening.

RICHLAND

Dr. Robert Wilson, superintendent of the Mansfield public schools, was the speaker at the September meeting of the Woman's Auxiliary to the Richland County Medical Society at Westbrook Country Club. The speaker showed effectively the comparison between available school facilities and the expanding student enrollment.

Mrs. Robert Crawford, president, conducted a business session. It was announced that the Richland County Medical Society and the Auxiliary will entertain Eleventh District doctors and their wives November 18 at the Mansfield-Leland Hotel.

ROSS

Mrs. G. Howard Wood presided at the dinner meeting of the Woman's Auxiliary to the Ross County Academy of Medicine on September 9 at Allyn's dining room. The program for the fiscal year was discussed and chairmen assigned to committees. Mrs. William Silbaugh and Mrs. E. H. Heisel of the Phi Beta Psi Sorority showed a film sponsored by the American Cancer Society.

SANDUSKY

The Woman's Auxiliary to the Sandusky County Medical Society held their September meeting with a dinner at the Yacht Club. The business meeting was conducted by the president, Mrs. L. E. Drassell. The following chairmen were appointed: Legislative, Mrs. E. A. Baker; Publicity, Mrs. W. J. Martin; Welfare Council, Mrs. J. L. Curtin; Program, Mrs. L. Moore; Historian, Mrs. M. M. Ridell; and State Magazine, Mrs. Harold Keiser.

SCIOTO

Mrs. Miller F. Toombs in Wheelersburg was hostess for the first fall meeting of the Woman's Auxiliary to the Scioto County Medical Association. The vice-president, Mrs. C. W. Wendelken, presided at the business meeting when plans were announced for the anniversary meeting to be held in October with Mrs. A. Paul Hancuff as special guest.

Mrs. Clyde M. Fitch showed pictures taken on her trip to the west coast, where she and Dr. Fitch attended the Medical Convention.

TUSCARAWAS

Launching its new season, the Tuscarawas County Medical Auxiliary met in September at the home of Mrs. R. C. Crawley, Seven-Mile Drive. The new president, Mrs. Paul Hahn, presided. Highlighting the meeting was the reading of the minutes of the first formal meeting of the group in September 1940, shortly after its organization.

An announcement was made that a district meeting would be held October 15 in Coshocton at the Country Club.

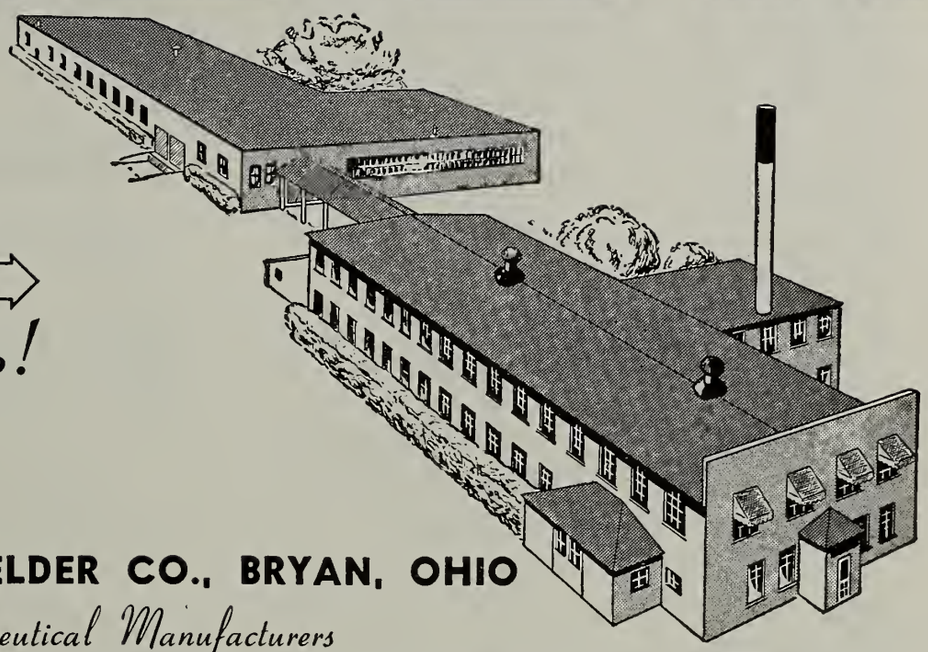
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New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since September 8, 1954. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

BUTLER COUNTY
Richard J. Glins, Middletown
Gilbert P. Wagoner, Middletown
Robert R. Williams, Middletown

CUYAHOGA COUNTY
Morton L. Angell, Cleveland
Richard F. Catalano, Maple Heights
Allen B. Dobkin, Cleveland
Sidney Katz, Grenville Rd., Cleveland
Hugh J. Leslie, Jr., Cleveland
Edward R. Malia, Cleveland
William B. Newberry, Jr., Cleveland
Richard J. Nowak, Cleveland
Joseph R. Paradise, Cleveland
Philip Ramer, Cleveland
George J. Salisbury, Cleveland
Sam I. Sato, Cleveland
Irwin Siegel, Cleveland

FRANKLIN COUNTY
Michael L. Cancilla, Pittsfield, Mass.
G. Thomas Drake, Columbus
Warren H. Leimbach, Bridgeport
Charles E. Long, Columbus
Joseph Macys, Columbus
William R. Morse, Columbus
Frederick I. Rose, Columbus
Jasper E. Sadler, Jr., Columbus

HARRISON COUNTY
Elias Freeman, Cadiz

KNOX COUNTY
Howard A. Dillon

LOGAN COUNTY
Charles A. Browning, Jr., Bellefontaine
John M. Wolfe, West Liberty

LORAIN COUNTY
Maynard J. Brucker, Amherst

LUCAS COUNTY
Robert B. Strother, Toledo
Robert J. Swindaman, Toledo
Wilbur A. Taylor, Jr., Toledo
Gregory J. Zann, Toledo

MAHONING COUNTY
Milan Halmos, Youngstown

MONTGOMERY COUNTY
Marvin C. Menne, Dayton

SUMMIT COUNTY
Robert J. Burkhard, Cuyahoga Falls
William M. Davis, Akron
Sidney C. Foster, Akron
John D. Hobensack, Akron
John W. McCoy, Akron
James G. Roberts, Akron

WAYNE COUNTY
Charles R. Bammerlin, Fredericksburg

ABC's of Rural Health Program

Ways the A. M. A.'s Council on Rural Health can help you and your community "help yourself to better health" are neatly spelled out in an attractive new brochure prepared by the Council.

The brochure is being distributed to state medical society rural health committees, agricultural and farm leaders, educators and others interested in the field. Additional copies may be secured upon request to Ohio State Medical Association, 79 E. State St., Columbus 15, Ohio.

Standard Nomenclature Institute

A new short course on the correct way of utilizing *Standard Nomenclature of Diseases and Operations* in the hospital, doctor's office or clinic will be offered February 7-9 at A. M. A. Headquarters, Chicago.

Because of limited facilities, registration will be limited to 150 "students." Application blanks will be distributed after December 1.

Congress on Physical Medicine Elects Officers

Dr. Walter J. Zeiter, Cleveland, was reelected executive director of the American Congress of Physical Medicine and Rehabilitation at the 32nd annual scientific and clinical session held in Washington, D. C., September 6-11. President of the organization is Dr. William D. Paul, Iowa City, Iowa, and Dr. Howard A. Rusk, New York City.

Executive offices of the organization are at 30 N. Michigan Ave., Chicago 2, Ill.

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Do You Know? . . .

Dr. Carll S. Mundy, Toledo, vice-chairman of the A. M. A. Council on Rural Health, spoke before the Seventh Annual Rural Health Conference sponsored by the West Virginia State Medical Association on the subject, "Highways of Rural Health."

* * *

Dr. Charles H. Rammelkamp, Jr., Cleveland, associate professor of preventive medicine at Western Reserve University, was awarded the 1954 Albert Lasker award of the American Public Health Association, at the organization's 82nd annual meeting in Buffalo, N. Y. He received the award on behalf of the Streptococcal Disease Laboratory, Armed Forces Epidemiological Board, Frances E. Warren Air Force Base, Cheyenne, Wyo., of which he is director.

* * *

Dr. John W. Wilce, for many years a promoter of football and other sports at Ohio State University, formerly as head football coach, was honored between halves at the Ohio State-California game by being inducted into the National Football Hall of Fame. Dr. Wilce is professor of medicine in the O. S. U. College of Medicine and director of the Student Health Center.

* * *

Dr. George Crile, Jr., Cleveland Clinic, was guest speaker at the October 12 meeting of the Fort Steuben Academy of Medicine in Steubenville, where he spoke on the subject, "Recent Advances in Surgery." Opening discussion on the talk was Dr. Samuel Harbison, of the Department of Surgery, University of Pittsburgh.

* * *

Dr. Gertrude Felker, Dayton, recently was named "Woman of the Year" by the Dayton Business and Professional Women's Club. A 50-Year member of the Ohio State Medical Association, Dr. Felker was cited for her early and continuous fight for sanitation standards in Montgomery County, particularly in regard to milk.

* * *

Dr. M. A. Blankenhorn, professor of medicine at the University of Cincinnati College of Medicine, addressed the regional meeting of the American College of Physicians, October 8 in Oklahoma City on "Acute Infections and Intoxications of the Myocardium." Dr. Blankenhorn, first vice-president of the American College of Physicians, represented the college as guest speaker at the regional meeting dinner.

* * *

Dr. John H. Skavlem, Cincinnati, accompanied by Mrs. Skavlem, attended the Thirteenth Conference of International Union Against Tuberculosis in Madrid, Spain. He is president of the National Tuberculosis Association and represented that organization on the Council of the Union.

Importance of Participating Physician List in Mine Workers' Fund Stressed

The importance of referral of fund patients to listed participating physicians in the United Mine Workers of America Welfare and Retirement Fund were stressed in a letter to participating physicians. The letter was signed by Dr. Leslie A. Falk, area medical administrator, with offices in Pittsburgh, Pa. It reads as follows:

"On or about September 20, 1954, you were mailed a copy of the newly issued Fund Pittsburgh Area Medical Information booklet. In addition to general information about the Medical Program, this contains complete lists of all participating physicians and specialists with whom we have business arrangements for routinely billing the Fund for their medical services.

"It is necessary to inform you that, effective immediately, it will not be possible for us to provide payment for services rendered our beneficiaries by physicians whose names do not appear on our lists as being current participants in our program. For this reason, we urge you to consult the lists when the occasion for making patient referral to a specialist or another physician arises. This is essential, whether the referral be within your own community or to a physician in a larger, nearby medical center.

"If, in your judgment, a particular problem requires the services of a specialist whose well-qualified counterpart is not included on our list of participating specialists, it is most important that the Area Medical Office be contacted IN ADVANCE of referral, via a "Request for Authorization" form 103-HS. Without the opportunity for decision based on the receipt of such advance information in our office, and the actual issuance of an authorization to bill the Fund for service to be provided, it will be impossible for us to accept billing for services resulting from such unauthorized referral to a non-participating physician. This, in most cases, will result in what we believe to be an unnecessary burden on the patient involved.

"Our lists contain the names of hundreds of physicians situated throughout our entire Area of western Pennsylvania, Ohio, and northern West Virginia. We urge that you use the lists whenever necessary."

International Proctology Meeting Scheduled in New York

The seventh annual convention of the International Academy of Proctology will be held at the Plaza Hotel, New York City, March 23-26. The international, national and local program committees are planning a seminar on anorectal and colon surgery. Additional information may be obtained from the Academy at 147-41 Sanford Ave., Flushing, N. Y.

Ohio Well Represented at Public Relations Conference

A number of Ohio physicians and lay executives of County Societies and the State Association attended the A. M. A.'s Public Relations Institute in Chicago September 1-2; among those in attendance were:

Dr. Mason S. Jones, public relations chairman, Montgomery County Medical Society;

Dr. W. J. Lewis, a member of the Montgomery PR committee;

Dr. Frank L. Shively, Jr., president-elect of the Montgomery County Society;

Dr. Aubrey L. Sparks, Trumbull County Medical Society.

Lay executives included:

Robert W. Elwell, Toledo Academy of Medicine; Robert F. Freeman, Montgomery County Medical Society; M. John Hanni, Jr., Cleveland Academy.

And from the Ohio State Medical Association, Charles S. Nelson, Executive Secretary; George H. Saville, director of public relations, and Hart F. Page, assistant PR director.

Approximately 300 persons from various county and state associations attended.

COMING MEETINGS

Ohio State Medical Association, 1955 Annual Meeting, week of April 18, 1955, Cincinnati.

American Medical Association, 1954 Clinical Meeting, Nov. 29 - Dec. 2, 1954, Miami, Fla.

American Medical Association, 1955 Annual Meeting, June 6-10, 1955, Atlantic City, N. J.

Frank E. Bunts Educational Institute, Cleveland Clinic, Postgraduate Course, Nov. 10-11.

Election Day, November 2.

Annual Clinical Congress of American College of Surgeons, Nov. 15-19, Atlantic City, N. J.

Cleveland Area Heart Society, Course in Resuscitation, November 19-20, December 17-18.

American College of Surgeons Section Meeting, Cleveland, February 21-24.

The Great Lakes Regional meeting of the American Association on Mental Deficiency met on October 8 in Columbus. The meeting comprised persons from Ohio, Indiana, Illinois, Michigan and Wisconsin. Dr. Roger M. Gove, now director of the State Juvenile Diagnostic Center in Columbus, described Ohio's mental deficiency program to the group.

Judge Henry J. Robison, director of the State Department of Public Welfare, was accorded the honorary degree of Doctor of Laws by his alma mater Kent State University "in grateful recognition of his distinguished contribution in human relations and social administration and long career of efficient public service."

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FOR SALE: Bargain, Picker fluoroscope, practically unused. Can be seen at Montgomery County Tuberculosis Clinic, 213 North Ludlow St., Dayton 2, Ohio. Contact E. F. Conlogue, Dayton. Telephone RA 1135.

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Cincinnati Area General Physicians Schedule Series of Seminars

The Southwestern Ohio Society of General Physicians, in collaboration with the University of Cincinnati College of Medicine, is offering four seminars in the medical school auditorium.

Seminar No. 1 will be held on four consecutive Thursdays, beginning November 4, 9:30 a. m. to 11:30 a. m. on "Recent Developments in the Specialties."

Seminar No. 2 will be held on Sunday, November 28, 9:30 a. m. to 3:00 p. m. on "Traumatic Orthopedics for the General Physician."

Seminar No. 3 will be held on Sunday, January 23, from 9:30 a. m. to 3:00 p. m. on "The Problem Drinker."

Seminar No. 4 is scheduled for Sunday, March 27, 9:30 a. m. to 3:00 p. m. on the subject, "The Doctor, the Coroner and the Law."

Fee for one session is $10; member's season fee $25. Residents, interns, medical students and nurses, will be admitted without fee.

Additional information may be obtained from Dr. J. Robert Hudson, secretary, 7017 Miami Ave., Madeira, Ohio.

WANTED: Part or full time physician in industrial and general practice, southwestern Ohio. Will consider applicant who is waiting for military service or future hospital appointment. Box 791, c/o Ohio State Medical Journal.

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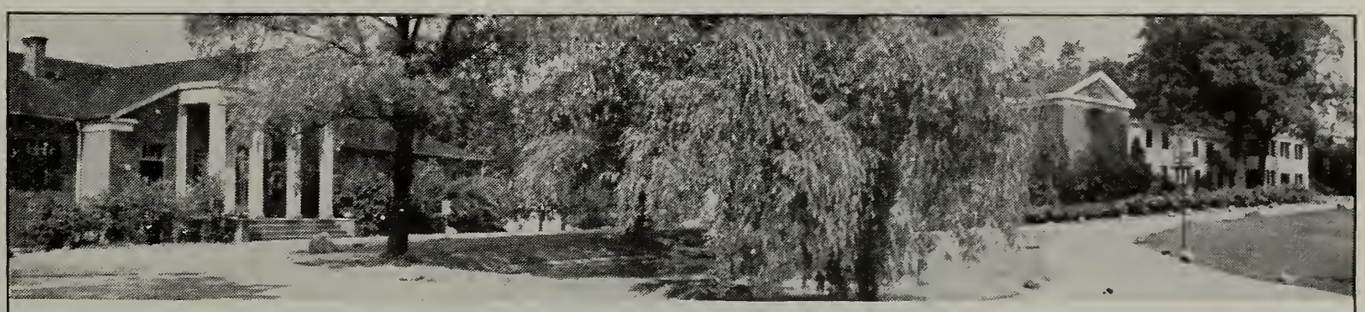
POSITION WANTED: Radiologist desires hospital position or group of rural hospitals in northern Ohio. Board certified in diagnosis and therapy; 32 years of age, married; military category IV. Box 790, c/o Ohio State Medical Journal.

Silicosis Conference

A conference on silicosis and occupational chest diseases jointly sponsored by the McIntyre Research Foundation of Toronto, Canada, and the Saranac Laboratory of Saranac Lake, New York, has been arranged for February 7-9, 1955, in the Town Hall at Saranac Lake.

Additional information may be obtained from Norman R. Sturgis, Jr., Saranac Laboratory, Saranac Lake, N. Y.





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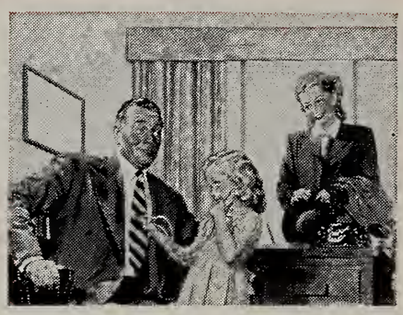








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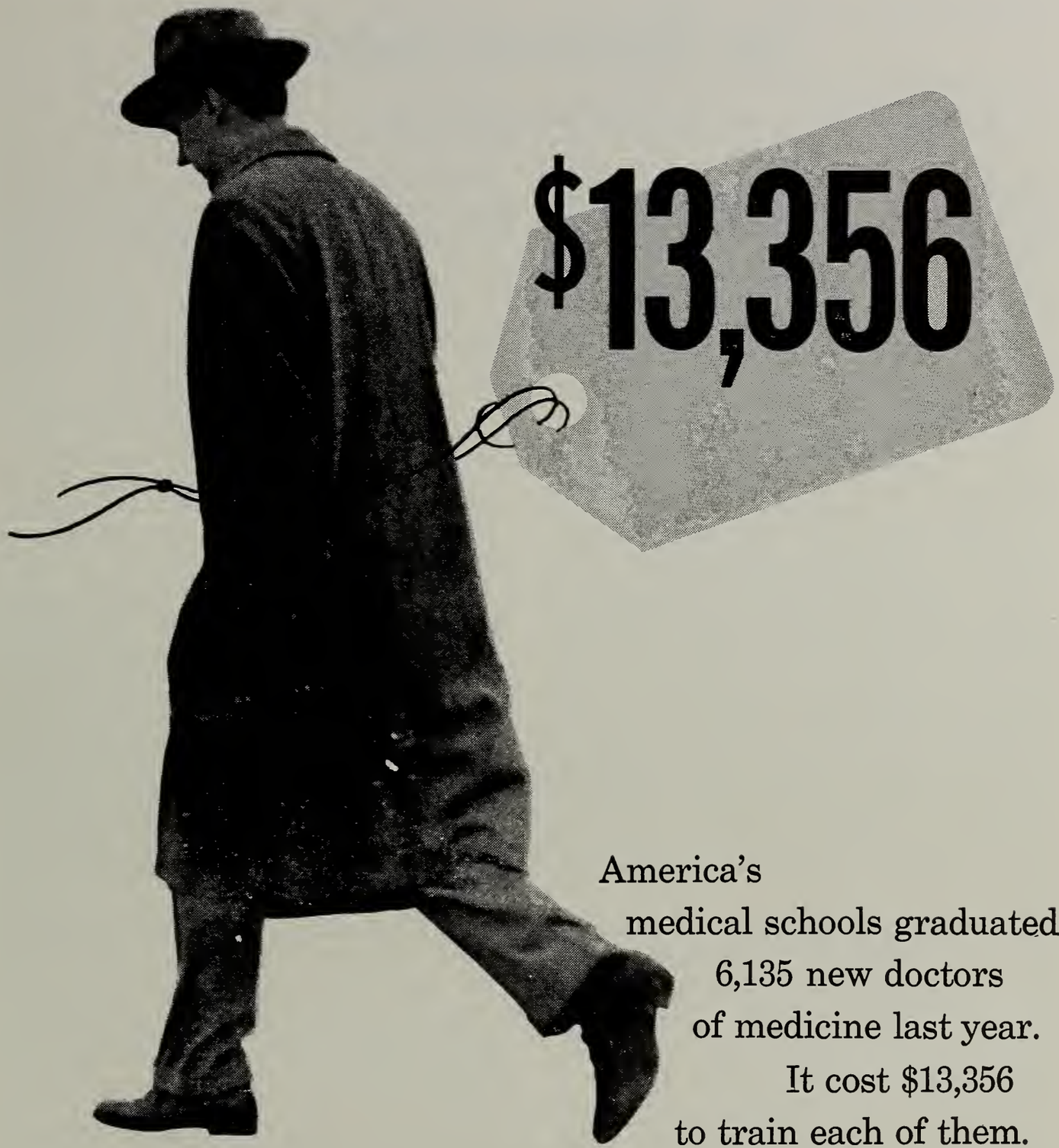
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Coronary Heart Disease in Young Adults, A Multidisciplinary Study, by Minard M. Gertler, M. D., Paul D. White, M. D., and others. ($5.00. A Commonwealth Fund Book, published by *Harvard University Press).* This is a report of a study conducted at Massachusetts General Hospital and the Harvard Medical School on coronary heart disease, by a staff of seven physicians. The purpose of the project was, (a) to study more intensively the existing clues as to the cause of coronary heart disease, and (b) to unite in a more cohesive fashion the various disciplines from which these clues stem. Accordingly, in this study, beginning in 1946, coronary heart disease was studied from the viewpoint of (1) Sex selection, morphological, genetic, athletic, occupational, physical, psychological, clinical, dietary, hormonial, and biochemical aspects. The study bears out the concept that the disease is caused by not one factor but by many. By taking into consideration all the factors that this research group did, it should theoretically be possible to pre-select coronary-prone individuals from the general population. If this works out, as it seems it will, it ought to be possible to institute preventive therapy to delay the episode of the attack on those individuals who are recognized to be coronary-disease-prone.

A Methodological Psychiatric and Statistical Study of a Large Swedish Rural Population, by Tage Larsson, and Torsten Sjögren, (25 kronen, *Ejñar Munksgaard, Norregade 6, Copenhagen, Denmark).* This book sets forth the investigation into the problems of mental disorders in the general population, as revealed in this study of a large rural area in Sweden. The aim of the study was to make a statistical and genetic analysis of psychoses and low-grade oligophrenia over a relatively long period and in a geographically limited area. The material covers 45 years of registration in a Swedish rural area with about 25,000 inhabitants, and 1312 registered cases of psychoses, severe psychopathics, low-grade oligophrenia and suicide.

Clinical Chemical Pathology, by C. H. Gray, M. D., ($3.00. *Edward Arnold & Co., London, England;* U. S. A. Distributor: *Williams and Wilkins Co., Baltimore 2, Md.).* A short text from the lectures given to students at King's College Hospital Medical School. It presents the features of the subject which the author thinks to be of value in gaining an appreciation of the clinical aspects of some diseases. A vast amount of information is crowded into twelve lectures, covering 125 small pages.

Physics for Medical Students, by James S. Rogers, ($5.50. Third Edition. *Melbourne University Press, Melbourne, Australia;* U. S. A. Distributor: *Cambridge University Press, New York 22, N. Y.).* For a physician or medical student wishing to review the principles of physics, this makes an interesting book because it illustrates the principles of physics by their application to physiology and medicine. It is a good place to learn the basic facts of electroencephalography, electrocardiography, the workings of the phase contrast microscope and the use of reflected objectives. It is really up to date, with chapters on nuclear transformation, electronics, and thermionic valves, the electric microcosmic rays, and photoelectricity.

Areas of Psychology, by F. L. Marcuse, ($5.00. *Harper & Bros., New York 16, N. Y.).* This is a text which tries to advance the subject as a science as well as a means of contributing to the human welfare. It is written from the thesis that valuable information on many of the so-called central problems of the science, such as learning, motivation and behavior, can be learned from workers who are concerned with the problems of mental institutions, court rooms and industrial management. Therefore, it is a text which will be helpful to any physician who will take the time to study it.

The Mayo Diet Manual, ($5.50. Second Edition. *W. B. Saunders Co., Philadelphia 5, Pa.).* This is the first revision of the standard diet manual of this clinic. The diets outlined are intended only as a guide for ordering and planning food for sick people. It is expected that individual variations will be allowed. Emphasis is placed on the fact that it is essential that the food served should be eaten by the patient if it is to be of value. Therefore efforts should be made to see that not only the proper amounts of foods be served, but that they be served in such a way that they will be consumed.

Fluid and Electrolyte Therapy, by Franklin L. Ashley, M. D., and Horace G. Love, M. D., ($3.00. *J. B. Lippincott Co., Philadelphia 5, Pa.).* This is a primer of fundamental principles for medical students and hospital house officers.

The Christian View of Sexual Behavior, by William Norman Pittenger, ($1.50. *Seabury Press, Greenwich, Conn.).* This is one reaction to the Kinsey Report, a revision of a series of articles appearing in the *Episcopal Church News* in the autumn of 1953.

The Microtomist's Formulary and Guide, by Peter Gray, Ph. D., ($10.50. *The Blakiston Com-*

pany, Inc., New York 22, N. Y.). This is a complete work covering the preparation of all kinds of objects for microscopic examination. First those objects that are too small and too delicate to be handled by the ordinary methods of management are discussed, and, far more important, the steps necessary to make permanent preparations of objects in tissue in such a manner that their structure may be clearly seen under the microscope. There are nearly 800 pages of encyclopedic material, put up in a most usable manner.

Cold Injury, Editor M. Irene Ferrer, M. D., ($4.00. *The Josiah Macy Jr. Foundation, Packanack, N. J.)*, is the publication of the transactions of the second conference dealing with the epidemiology of cold injury in man, his resistance to cold and the pathophysiology of cold injuries.

An Rh-Hr Syllabus—The Types and Their Application, by Alexander S. Wiener, ($3.75. *Grune & Stratton, Inc., New York 16, N. Y.)*, presents the complex serology and genetics of Rh-Hr types; directions for performing Rh antibody tests and titrations by the agglutination, conglutination, blocking, antiglobulin and enzyme methods.

Nature and Nurture—A Modern Synthesis, by John L. Fuller, ($0.85. *Doubleday & Company, Inc., Garden City, N. Y.)*. One of the Doubleday Papers in Psychology by a researcher of many years into the problem of the inheritance of social behavior.

Perception—A Transactional Approach, by William H. Ittelson, and Hadley Cantril, ($0.85. *Doubleday & Company, Inc., Garden City, N. Y.)*. Another Doubleday Paper in Psychology which reviews in order the nature of perception, how it is studied, its operation.

Intelligence—Statistical Concepts of Its Nature, by L. J. Bischof, ($0.85. *Doubleday & Company, Inc., Garden City, N. Y.)*. Another Doubleday Paper in Psychology which reviews the development of theories of intelligence.

Nursing Team Organization and Functioning, by Eleanor C. Lambertsen, ($2.25. *Division of Nursing Education, Teachers College, Columbia University, New York)*, is an outgrowth of experimentation designed to solve the problem of utilizing nursing personnel in hospitals most advantageously—professional, student, practical nurses and nurses' aides.

Fluid and Electrolyte Therapy, by Franklin L. Ashley, M. D., and Horace G. Love, M. D., ($3.00. *J. B. Lippincott Co. Philadelphia 5, Pa.)*. A primer, in simple form, presents the fundamental principles of this basic subject for branches of medicine and surgery.

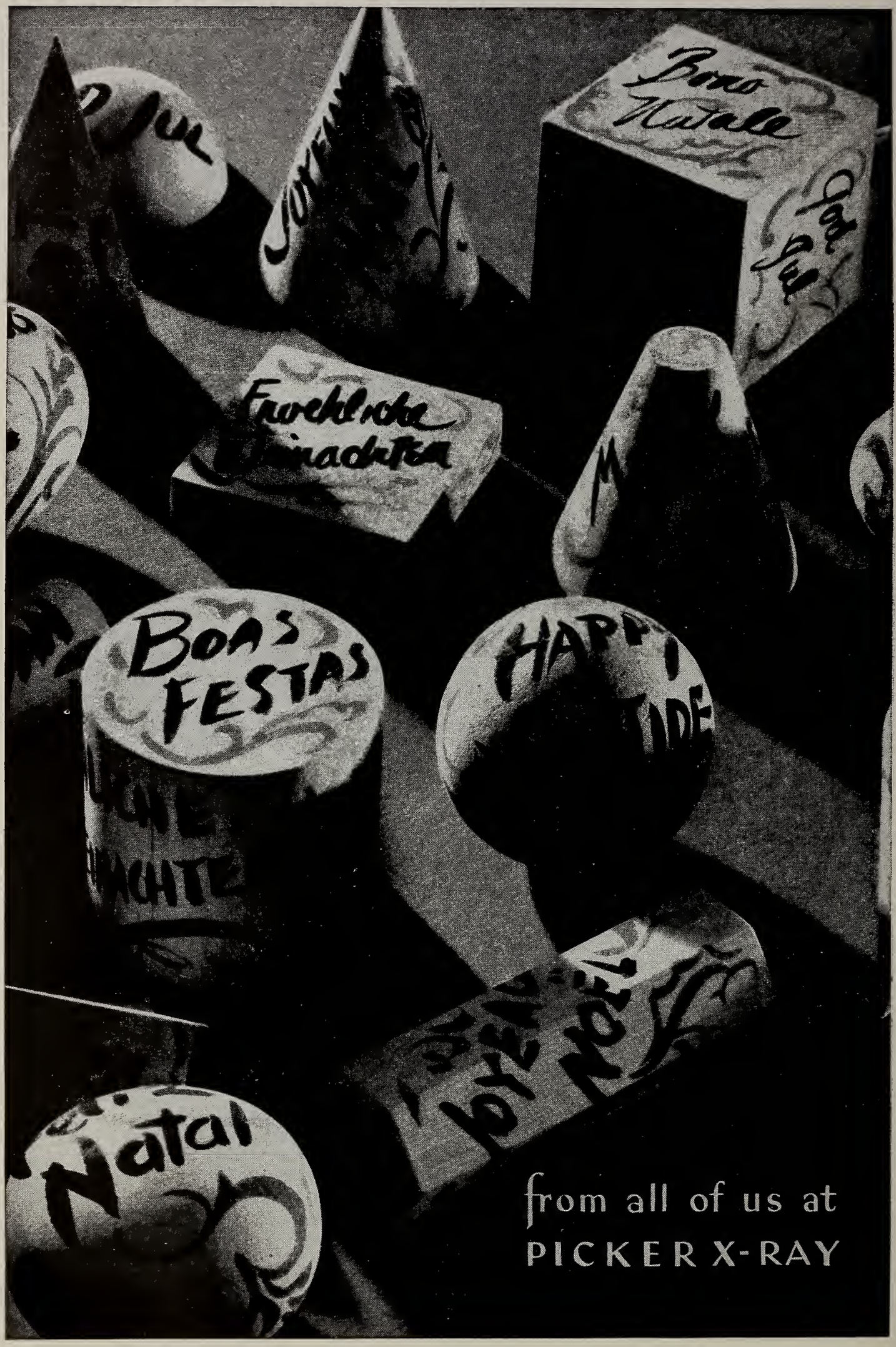
The Conquest of Fatigue and Fear, by Edward Spencer Cowles, M. D., ($2.95. *Henry Holt & Co., New York 17, N. Y.)*, a clear exposition of how this distinguished and most successful physician treats his patients.

The Origins and History of Consciousness, by Erich Neumann. Translated from the German by R. F. C. Hull, ($5.00. 42nd in the Bollingen Series, *Pantheon Books, Inc., New York 14, N. Y.)*. This is a new and creative interpretation of the relationship between psychology and mythology, by a distinguished Jungian analyst. The author's thesis is that individual consciousness passes through the same archetypal stages of development that marked the history of human consciousness as a whole. Among the myths discussed are the universal myths of the world's creation, the Earth-Mother, the Birth of the Hero, the Slaying of the Dragon, the Rescue of the Captive, the Transformation and Deification of the Hero. The hero, according to the author, throughout this sequence, is the evolving ego-consciousness.

The Management of Pain, With Special Emphasis on The Use of Analgesic Block in Diagnosis, Prognosis, and Therapy, by John J. Bonica, M.D., ($20.00. *Lea & Febiger, Philadelphia 6, Pa.)*. The purpose of this book is to present within one volume the complete discussion of the fundamental aspects of pain, the various diseases and disorders in which pain constitutes a major problem, and the methods employed in its management, with special emphasis on the use of analgesic block. This age-old problem of pain is treated in an encyclopedic fashion, in some 1533 pages. The book consists of three parts. First, a discussion of the fundamental aspects of pain; second, methods and techniques of managing pain; and third, a presentation of the various diseases and disorders with painful syndromes that can be managed by blocking.

An Atlas of Operative Technique, Anus, Rectum, and Colon, by Harry E. Bacon, M. D., and Stuart T. Ross, M. D., ($13.50. *The C. V. Mosby Co., St. Louis, Mo.)*. Since a surgical atlas provides a pictorial guide for the surgeon as it emphasizes technical details that are difficult to describe in the text, we find here 403 illustrations that tell the story much better than words. It should prove a welcome addition to the literature dealing with that phase of surgery which extended itself widely in recent years. The operations now used by the proctologists may have a detail and a magnitude comparable to any performed within the abdomen.

An Atlas of Orthopedic Traction Procedures, by Carlo Scuderi, M. D., ($12.50. *The C. V. Mosby Co., St. Louis, Mo.)*. Gathered in this volume are the illustrations of the important features essential for the successful use of orthopedic traction procedures. The illustrations are admirable and clear, and concisely demonstrate the necessary steps. The page opposite the illustrations gives a clear description of the device and the principles involved in its use.


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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 50 December, 1954 No. 12

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Iodine Deficiency—A Public Health Problem*

JOHN D. PORTERFIELD, M. D., M. P. H., and IZOLA WILLIAMS, M. S.

THE problem of simple goiter has been known to mankind for several centuries. The ancients used seaweed and burnt sponges to cure "swelling of the neck" with no knowledge of the scientific basis for these remedies.

Shakespeare, in Act III of *The Tempest*, described goiter in the voice of Gonsalo:

> "When we were boys
> Who would believe that there were mountaineers
> Dewlapped like bulls, whose throats had hanging at them
> Wallets of flesh; or that there were such men
> Whose heads stood in their breasts?"

As has been the case concerning many different ailments of humanity, until the true cause of simple goiter was established many theories of cause were advanced. Dr. J. Saint-Lager listed 43 that had been proposed by writers up to 1867. Nineteen of these concerned water supply, eleven were related to atmospheric influences, six related to nutrition and poverty, and the seven remaining were a miscellaneous assortment of causes including alcoholism, licentiousness, and consanguinity in marriage. Saint-Lager dismissed all except those connected with water supply as untenable, but concluded his paper with the words "we do not know."[1]

As long ago as 1820 a French physician, J. F. Coindet, successfully demonstrated the use of iodine as a cure for enlarged thyroid gland, or simple goiter. Thus the recognition of idoine as being in direct relationship to goiter began in the second decade of the 19th century, but the causal nature of this relationship developed slowly over a period of one hundred years.

About 1846 Prevost, a Geneva physician, collaborated with Maffoni, an Italian colleague, to suggest that the lack of iodine was the cause of goiter. At the same time, the French chemist, Gaspard Chatin, made extensive studies of the iodine contained in air, water, soil, and animal and vegetable foods from many parts of France. The results of these studies, which were published in 1850, led Chatin to a definite conclusion that the deficiency of iodine in the soil and water was associated with goiter. One or two anomalies in Chatin's study caused the French Academy of Sciences to report unfavorably on his work, and in consequence the iodine deficiency theory of goiter causation lay discredited and forgotten for more than 40 years.

In 1895 Baumann, a German chemist, made the discovery that iodine is a normal constituent of the thyroid gland. This discovery revived interest in Chatin's work and brought about a series of studies of the relation of goiter incidence to the geographical distribution of iodine. These studies, conducted in the United States, Switzerland, New Zealand, and Great Britain,

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*Presented at the Second Ohio Nutrition Conference, April 1, 1954, at Ohio State University.

proved beyond reasonable doubt that environmental deficiency of iodine is the primary cause of endemic goiter.

Since in those days there were no radio or television broadcasts and few daily newspapers, and people were as reluctant to accept simple new remedies for old ailments as they are now, it was years before the average citizen became aware of the possibilities for the prevention of goiter. Then it was brought to public attention by the unselfish devotion to the problem of developing practical methods of preventing goiter in whole populations of such public-spirited physicians as Marine and his pupil Kimball.

EARLY STUDIES IN GOITER PREVENTION

Ohio can be justly proud of her important role in the prevention of simple goiter. Marine and Kimball carried out an original experiment in goiter prevention in Akron from 1916 to 1920.[2] Approximately 5000 girls ranging in age from 11 to 18 years agreed to undergo preventive treatment, which was 3 grains of sodium iodine taken daily in drinking water, for a period of 10 days in the spring and in the autumn. An equal number who would not agree to take treatment served as controls. Of the experimental group, only 0.2 per cent developed any enlargement of the thyroid gland, while 27 per cent of those in the control group developed goiter. Many of the experimental group had enlarged thyroid gland at the beginning of the experiment and, of these, 79 per cent showed a decrease in the enlargement when the iodine deficiency was corrected.

When young men were drafted into the U. S. Army for World War I, more than 11,000 of those examined were found to have simple goiter. Some whose necks were so enlarged that they made buttoning the army uniform tunic impossible were rejected for army duty for this reason. Scientists studied the geographical distribution of the incidence of goiter in this segment of the population and, combining this information with the then current studies of iodine content of soil and water, made the first goiter map of the United States. From this map it was observed that our nation had an area bordered on the east by the Appalachian Mountains and extending westward through Ohio, Michigan, Wisconsin, Minnesota, the Dakotas, Montana and Oregon, with a high rate of simple goiter and a low iodine content of soil and water. In addition, it was noted that the lower the soil and water iodine content, the higher the goiter rate. This area became known as the goiter belt.

SURVEYS OF SCHOOL CHILDREN IN THE GOITER BELT

In 1922, through the encouragement offered by the National Goiter Study Committee, several state health departments in the goiter belt began surveys of school children to determine the incidence of enlarged thyroid.[3] Michigan surveyed children in four counties which were selected as representative of the various areas of the state and found that in school children of all ages, the incidence of goiter was 38.6 per cent.

Ohio made a similar survey limited to adolescent children in 1925. Six counties were selected as representative of average conditions in the state and 60,000 children were examined for thyroid enlargement. The incidence of goiter ranged from a low of 18 per cent for boys to a high of 44 per cent for girls in one county. The overall incidence was 24.2 per cent for boys and 40.5 per cent for girls. Much controversy arose over these figures, and as a consequence they were never published.

In the development of goiter prevention measures, Marine and Kimball used sodium iodide in the drinking water in their experiments in Akron. Later, this iodide was added to chocolate candy to make it more acceptable and was distributed to children in the Cleveland area as a goiter preventive measure.

A study in 1922 of the incidence of goiter among adolescent girls in the Charleston-Huntington area of West Virginia revealed that approximately 60 per cent of the girls had visible enlargement of the thyroid gland.[4] Investigators were told by older residents of the area that endemic goiter had been unknown there prior to 1900, but that soon after that date goiter became prevalent and a rapid increase in the rate had been noted.

IODINE IN SALT DEPOSITS

A study of the changes in dietary practices that took place in the area about that time showed that the only widespread alteration was a change from the use of a coarse, brownish salt which came from the salt wells along the Kanawha River to refined, white, free-flowing salt brought in by Michigan and Ohio salt companies. The brown salt was analyzed and found to contain approximately 0.01 per cent iodine. The refined salt contained none. Since the soil and water around Huntington are low in iodine, the residents of the area had unknowingly cut off their only supply of food iodine by changing to the refined salt. Further proof was shown in the lack of goiter among domestic animals. Farmers had continued to use the unrefined, iodine-containing salt for their livestock, thus preventing in these animals the goiter that is commonly seen among warm-blooded animals in goitrous areas.

ADDITION OF IODINE TO REFINED SALT

The West Virginia study suggested that a possible way to prevent goiter in large population groups would be to use salt containing iodine. Certain areas of the Midwest had used iodized rock salt for animals for several years with good results. Since the unrefined salt appeared to be dirty and inconvenient to use, it was unpopular despite its iodine content. The problem seemed

to be one of restoration of iodine to the salt after the refining process, or, in the case of some salt wells with low iodine content, the addition of enough iodide to prevent goiter when salt is used normally.

After some experimentation with the addition of iodides to salt it was found most satisfactory to add potassium iodide. Many salt manufacturers were found to be cooperative in the matter of producing iodized salt, especially when health agencies and medical groups promised to encourage its use. This approach to the problem of iodine deficiency and simple goiter was decided upon about 1925 and put into practice on a widespread basis in Michigan about that time.

Ohio joined in this movement, but was handicapped by lack of agreement among outstanding members of the medical profession regarding the desirability of using iodized salt. Some members of the profession contended that generalized usage of iodized salt would produce an increase in toxic goiter, a type of goiter that is associated with an over-active thyroid gland. In order to determine whether this was a valid claim, Michigan re-surveyed the four counties of the 1922 survey in 1927 and 1928 to learn the efficiency of iodized salt in preventing goiter and to determine any harmful effects from its continued use. In addition to the survey of children, it was necessary to study adults with goiters to see if any cases had become toxic during the previous four years. County medical societies and the Michigan State Health Department arranged clinics to study 1,229 adults with long-standing goiters. They found that 4.1 per cent of those who had used iodized salt continuously for the four years had developed symptoms of toxic goiter, while 55.5 per cent of those who had purposely avoided its use were found to have toxic goiter.[5]

Evidently this study was not given good circulation in medical circles in Ohio, for in the early 1930's we had, and even today we have, members of the medical profession who talk of the "dangers" of using iodized salt. This severe criticism seemed to be so concentrated in the Cleveland area that school children in that area were re-surveyed in 1937 and figures compared with a survey made in 1924. Less than one-half of the homes in Cleveland used iodized salt. Many persons were avoiding its use, because of the divided medical opinion. Again, it was shown to be "not guilty" of the dire things predicted by its accusers . . . and again it was shown to be an effective way of preventing simple goiter. The rate of goiter among children using iodized salt was 7.7 per cent as compared with a rate of 30.7 per cent among those who did not use iodized salt.

THE PUBLIC HEALTH ASPECTS OF IODINE DEFICIENCY

A summary analysis of the experiments and surveys concerning iodine deficiency and simple goiter demonstrates very clearly that iodine deficiency is a primary cause of simple goiter and that the problem is one affecting the health of the general population of goitrous areas. Therefore, few will deny its assignment as being "a public health problem." We add to the validity of this statement when we recognize that the control of simple goiter is principally a matter of prevention.

Perhaps it would be fitting at this point to examine some of the data regarding the function of the thyroid gland and the long-time results of a lack of sufficient iodine in the diet. If enlargement of the thyroid gland were the only result of iodine deficiency, the problem would be merely one of esthetics and would be generally regarded as one of minor consequence to the public health. However, as long ago as the sixteenth century Felix Platter, who occupied the chair of medicine at the University of Basle for 43 years, gave an accurate clinical description of cretinism and noted its relationship to endemic goiter.

Marine at Western Reserve University made repeated studies of the chemistry and physiology of the thyroid gland from 1905 to 1912. He found that a primary function of the thyroid gland is to produce a hormone called thyroxine. This hormone is necessary for normal growth and development from conception to maturity. His studies further revealed that the thyroid gland cannot function properly without iodine and that lack of normal activity of the gland produces ill effects, often permanent, in the human body. Kimball and Marine point out in an article on the relation of endemic goiter and mental deficiency that "if the mother's thyroid is not functioning well during pregnancy, the child will suffer some degree of cretinism or cretinoid type of mental deficiency."[4] There is much evidence to suggest that lack of proper thyroid function is associated also with increased incidence of deaf-mutism, abortion and stillbirth.

Although iodine is an essential element in human nutrition, the quantity needed is very small. The National Research Council, in its recommended daily dietary allowances, gives the daily need for iodine as about 0.002 mg. to 0.004 mg. for each kilogram of body weight. This would mean a total daily requirement of from 0.15 mg. to 0.30 mg. for adults. The Council gives emphasis to the increased need for iodine during adolescence and pregnancy.

IODINE DEFICIENCY AND INTERNATIONAL HEALTH PROBLEMS

In keeping with our great interest in international relations, it is pertinent to consider the problem of iodine deficiency in other parts of the world. The World Health Organization held a conference on endemic goiter in London in December of 1952 to define the magnitude of the

problem from a public health point of view.[6] Today endemic goiter appears to be primarily a problem of the economically under-developed areas of the world. The iodine content of the soil and water of goitrous areas has not changed, but such countries as Switzerland, Great Britain, the United States, Mexico, and Yugoslavia have used educational and legal measures to help their citizenry provide needed iodine in the diet.

Switzerland, which once had large colonies of cretins, is now able to use these state institutions for other purposes. Japan has soil deficient in iodine, but the use of large quantities of seaweed in the national diet meets the need for iodine very adequately. Some parts of China, and the northern part of India are not so fortunate. In Himalayan villages, nearly 70 per cent of the population is affected by goiter. Our neighbors in Central and South American countries have a problem in iodine deficiency too. Kimball reviewed the situation in Mexico, Guatemala, Colombia, Ecuador and Peru in 1950. Of this study he writes:[2]

"In these countries I found great variations in the incidence of endemic goiter. The white urban population is comparatively free from goiter, while out in the mountainous areas only a few miles from cities, goiter, with all its degenerative conditions, is very common. In an Indian Village only 25 miles from Mexico City, 65 per cent of the total number of inhabitants had unmistakable goiter. Cretins were common and deaf-mutes were more frequent than we had ever expected to find. The same condition obtained in Guatemala and all the other Central American States, and in Colombia, Ecuador, and Peru."

In Colombia, Kimball and his associates found another example of a natural iodized salt completely preventing endemic goiter for centuries with no evidence of harmful effect. In the province of Caldas, on the west slope of the Andes, all food salt came from one mineral spring until 1915. Up to that year goiter and cretinism were unknown in Caldas, although there was high incidence of both in all adjacent areas. At that time an owner of a salt mine on the eastern slope of the Andes began using a more modern method of refining his product and was able to produce a better grade of salt at lower cost. He shipped salt to all parts of the country and soon put his competitors out of business. This was a thrilling success story for the salt mine owner, but a tragic one for the people of Caldas. Just as in the case of West Virginia the people had discarded their one source of food iodine. In 1945 the Caldas Health Department surveyed its population and found that 85 per cent of school children had goiter and that every parochial district had a home to take care of cretins.

It can be readily understood that normal function of the thyroid gland is essential for the health of mothers and children and for the reduction of the incidence of certain types of mental deficiency. Since cures are ineffective in the control of such tragedies as cretinism and deaf-mutism, it is obvious that the matter of prevention is of overwhelming importance in dealing with this problem. Marine has pointed out that simple goiter is the easiest known disease to prevent. Certainly, the evidence we have shows this statement to be undeniably true.

PRESENT SITUATION IN OHIO

It is important now to consider the question of whether we are preventing simple goiter, and other ill effects of iodine deficiency today. Are we using the scientific knowledge so laboriously gathered over the centuries to promote better health of our citizens? Does our present generation know that the lack of iodine in the diet is a serious health hazard? Is it aware that the use of iodized salt is a simple way to avoid this hazard? Is it realized that the lifetime care of one feebleminded child may cost taxpayers more money than adding iodine to the salt for our state's entire population? In short, what is our present situation?

We know that the present incidence of simple goiter in Ohio is not as high as it was in 1925, but we have no figures that will tell us how much we do have. Michigan re-surveyed in 1952 the four counties of the first survey and found that the incidence of enlarged thyroid among school children had dropped from 38.6 per cent in 1922 to 1.4 per cent in 1952, an accomplishment in preventive medicine which is a credit to health departments, physicians, and schools.[7] In addition, it was found that 58 per cent of the salt sold in small or family size packages in that state is iodized.

This spring, the Ohio Department of Health and the College of Medicine of Ohio State University began a joint project to re-survey school children in four of the six counties surveyed in 1925. These counties are Union, Butler, Marion, and Washington. Thirty thousand children are being examined for the presence of enlarged thyroid gland and their parents will be questioned regarding their usage of iodized salt. When the study is completed we will determine our present incidence of simple goiter and compare it with the figures obtained in 1925. Thus we can see how effectively we are preventing simple goiter and how widespread and consistent is our usage of iodized salt.

We do not know what proportion of Ohio's citizens is aware of the importance of food iodine to health. We assume that Colleges of Medicine and Colleges of Home Economics include such information in nutrition courses. Some textbooks used in secondary schools touch

on the subject of iodine in human nutrition, but since few of these books are written specifically for this geographic area, no emphasis is given to this phase of nutrition, unless the teacher is aware of the need for such emphasis. Nutrition consultants with the Ohio Department of Health and nutritionists in voluntary health agencies recommend the daily use of iodized salt. Public health nurses often tell of its importance in their home visits and contacts with schools. Most physicians encourage the use of iodized salt, but a few still warn of its dangers.

A few years ago when our nutrition consultants began visiting Ohio's one hundred and fifty children's homes to evaluate their food service, very few were found to be using iodized salt. They began using it when told of the need, but it is a problem of continuous education when there are personnel changes in these homes. A similar situation exists in school lunchrooms throughout the state.

We have reason to believe that other states in the goiter belt have situations similar to that of Ohio. Possibly some states, such as Michigan, whose problems were more acute in 1922, have made greater progress in reducing goiter incidence. When the present study is complete, Ohio's results will be reported.

OUTLOOK

What of the future of iodine deficiency? Can we consider it a problem mainly of the past, as we now consider beri-beri, rickets and pellagra, or is it a recurring problem requiring education of each new generation in the goitrous areas? Since it appears impractical to add iodine to the soil and water of the goitrous areas, we can assume that iodine will continue to be very low in the natural environment of people who live in the goiter belt. To add the needed iodine to the diet of all the people requires a widespread educational program repeated every 10 to 15 years. In order to avoid the great expense of repeated educational programs, it has been recommended that a law be passed requiring addition of iodine to all table salt. This idea was rejected by the U. S. Congress as being an invasion of States' rights. It is possible that in time states may exercise this right for the permanent protection of their people. This action will depend on the extent of voluntary preventive action.

Meanwhile, we who are interested in health and education should feel a responsibility for letting Ohio's citizenry know that we still have iodine-deficient soil; that the daily use of iodized salt is a simple and inexpensive precautionary measure that has been shown to be effective in preventing iodine deficiency;—that a well balanced diet which includes iodine-rich foods such as fish and other seafoods is an additional and very pleasant preventive measure now within reach of most families.

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Antibodies as Causes Of Human Diseases

The group of diseases which are being studied for evidence of antibody causation includes most of the members of the collagen group and may be listed as glomerulonephritis, rheumatic fever, lupus erythematosus, polyarteritis nodosa, and related entities.

Are transfusions contributing to the problem? Realizing the tremendous number of antigens contained in whole blood—which now apparently includes a number of platelet types—can one expect to give multiple transfusions without causing *iso*antibodies to develop and perhaps complicate the course of the patient's illness? Certainly one cannot expect to match blood so that donor and recipient are antigenically the same. It is increasingly apparent that with the advent of the use of corticotropin and cortisone one can use transfusions less and less in diseases in which an immune mechanism is concerned.

In many other situations, the information assembled concerning the development or occurrence of *iso*antibodies and *auto*antibodies in human disease may well be considered before elective transfusion therapy is practiced.—Harold D. Palmer, M. D., Denver: *Texas State J. M.*, 50:471, July, 1954.

Struma Ovarii

Struma ovarii is an ovarian teratoma of thyroid tissue. Twenty per cent of ovarian teratomas contain thyroid tissue; in more than 120 reported cases, this element had overgrown to such an extent as to make the resulting tumor an ovarian goiter. In 5 per cent of these cases, clinical evidence of thyrotoxicosis was present, which sometimes led to unnecessary operations on the neck in an effort to prepare the patient for a major pelvic operation. Radioiodine in tracer doses is the current answer to these anomalous situations. Pathologically, these tumors resemble nodular rather than exophthalmic goiters. Ascites is a frequent accompaniment, and malignant change is observed in 5 per cent of the lesions.—Malcolm B. Dockerty, M. D., Rochester, Minn.: *J. Florida M. A.*, 41:184, Sept., 1954.

Cervical Cytology and the Gynecologist

GEORGE M. WILCOXON, M. D.

"IF a woman over 40 years of age has a Cervical Cytology Study every six months she will not die of uterine malignancy." This statement was made a few years ago and is gradually proving to be a true observation. In this study when cervical cytology study is mentioned the study is by the Papanicolaou method, the cells having been taken from the uterine cervix by aspiration and cervical scraping at the time of a complete pelvic examination of the patient.

For years in the taking of Papanicolaou smears of the cervix it has been recommended that before any part of the examination is done a speculum be inserted in the vagina and the smear taken. This means the speculum must be removed from the vagina and the vaginal examination completed and then the speculum reinserted in the vagina, if any treatment of the cervix is necessary by the gynecologist.

We complete the vaginal examination and then insert the speculum and take the cervical smear and scraping. This saves considerable time on each patient. The real difference is that **only a very small amount of lubricant** should be used. By using a small amount of lubrication none of the lubricant reaches the cervix.

DIFFERENT LUBRICANTS USED

Most physicians use too much lubricant in doing a vaginal examination. Too much lubrication makes the examination more difficult. It takes time to get used to a small amount of lubrication, but once accomplished it gives better palpation of the pelvic organs.

For some time we have discarded the older lubricants and have been using pHisoHex® as a lubricant. It is contained in a small, easy to handle, plastic, squeeze bottle. Not more than one half inch of the pHisoHex® is squeezed on the index finger of the examining hand. This is then spread around the orifice of the vagina and the index finger inserted into the vagina. If the vagina will take two fingers the second finger is then inserted.

The complete bimanual vaginal examination is then finished and **without any further lubricant on the speculum** it is inserted. The cervical aspiration and cervical scraping is then done. It does not make any difference whether or not the patient has taken a douche before the examination.

Thus, every time a cervical cytology study is mentioned the full meaning is that a complete pelvic examination is done by a gynecologist before the actual taking of the Papanicolaou test. If a woman over 40 years of age has a cervical cytology study every six months she will not die of a uterine malignancy because the cancer will be recognized early and proper modern treatment started in time to effect a cure.

Submitted February 10, 1954.

The Author

● Dr. Wilcoxon, Alliance, Ohio, is head of the staff, gynecology service, at City Hospital in Alliance.

PUNCH BIOPSY

The punch biopsy of the uterine cervix is rapidly becoming obsolete because it is unfair to the physician and to the patient. It is now known that a small area of the cervix can have a cancerous area right next to the punch biopsy area. Even multiple punch biopsy areas might miss a malignancy of the cervix.

Here is a quotation from McDonald and Dahlin:[1] "A single properly prepared cervical smear is more accurate in the detection of preclinical carcinoma than is a single conventional biopsy specimen, mainly because the lesion is so not often grossly apparent."

There has been considerable comment concerning the false security given the patient if a cytology study is misinterpreted. How much more false security is given if the very small area of the punch biopsy misses the malignancy! The doctor and the patient give the cervix a "clean bill of health" while the missed malignancy goes on its destructive course. An entire circular area of the cervix must be removed and studied, according to Hoffman, Forel and Hahn,[2] to make sure a cancer is not present. For this reason cervical cytology study is much more practical than a punch biopsy of the cervix.

We agree with Barnes and Hendricks in their statement: "A cervix bad enough to cauterize is bad enough to biopsy."[3] We believe that before cauterization of the cervix a cervical cytology study should be done and reported on so that a cervix with positive cells will not be cauterized and eliminate all possibilities of a complete diagnosis.

Routine biopsies of normal appearing cervices not infrequently fail to disclose an existing cancer according to Fremont-Smith and Graham.[4]

Many general practitioners are availing them-

selves of this valuable adjunct to diagnosis by having cervical cytology studies done on their women patients. The general practitioner either sends his patient to the gynecologist who does such a study or he does the pelvic examination himself and sends the slides to a private laboratory which concentrates on cervical cytology.

It is surprising how many general practitioners will not do a complete pelvic examination on their women patients. Within the month a patient presented herself who had been going regularly for five years to "her doctor" who had not done a pelvic examination even though the patient suggested it. At the pelvic examination as the patient separated her thighs, there protruding from the vaginal orifice was the scarred nose of the cervix. If "her doctor" had just looked he could have made a partial diagnosis without ever putting on a glove.

GYNECOLOGISTS NEED CERVICAL CYTOLOGY STUDY

Some gynecologists are also availing themselves of cervical cytology studies but because they are specialists in the field they sometimes feel that their observations of the uterine cervix are enough to tell them whether or not a malignancy is present. Cervical cytology study will tell when a malignancy is present when the gynecologist cannot possibly see it by direct observation of the cervix.

A gynecologist who has been trained to read cervical cytology has a great advantage over his specialist colleague who has not had this special training. It gives him a greater understanding of the cells exfoliated from the uterus. It gives him a confidence which only one who has had the experience can understand.

Whether a physician is a specialist or not, it is impossible to look at the uterine cervix through the vaginal orifice and tell if a malignancy is present in the uterus. Of course, any specialist in uterine cancer can tell a malignancy if it falls in his line of vision as he observes the cervix. But, the malignancies we are interested in do not present themselves and are not in the line of vision of the observer. They are in the "hole," or in the canal, or higher, where it is impossible to see or palpate them. These are the early malignancies we are after because with proper treatment they give the highest cure rate.

Therefore, the gynecologist or specialist who has decided in his mind that he can tell a malignancy of the uterus by palpation and observation is sometimes the most reluctant to use the cervical cytology study.

When the gynecologist does use the cervical cytology study along with his specially developed powers of observation it gives him a tremendous advantage in border-line cases. In cases where the cytological study is very difficult to interpret the case can be followed very closely and repeated observations and studies made until a definite and correct conclusion is reached for the patient.

This is one place where constant observation of the living patient and direct study of the exfoliated cells from the patient in the laboratory tie together to give medicine one of the great advantages of science working for the survival of the human being.

STAGE 0 CARCINOMAS

Cervical cytology has played a great part in the fairly recent International Classification of Stage 0 carcinoma of the cervix. Stage 0 carcinomas of the cervix have been with us for years but it is only recently that they are being recognized as such and classified as they should be.

Preclinical carcinoma of the uterine cervix was formerly found only when the cervix was removed for some other reason, the diagnosis being made in the pathological laboratory by the pathologist after the excision and preparation of the tissue. Cytology has changed this procedure and has opened up an entirely different conception of this dangerous lesion. It is here that cervical cytology and the gynecologist can play the greatest role in reducing the cancer death rate in women.

Several articles have been written expressing the period of time involved from the beginning of a cervical carcinoma until it can be recognized clinically. Most of the authors agree that it is a matter of years. That means that every day many women are repeatedly going in and out of the offices of physicians without their preclinical cervical carcinomas being recognized. This can all be controlled by the cervical cytology study.

ESTIMATED ESTROGEN LEVEL

During the cervical cytology study it is possible to rate the number of bacteria present and to decide if the organism *Trichomonas vaginalis* is present. On all our private patients an estimated estrogen level is done.

There has been an indiscriminate use of injectable estrogens in the past few years. It is suggested here that each patient have an estimated estrogen level done before receiving any estrogens. This is easily accomplished in the cervical cytology study and if the patient's estrogen level is low she can receive daily oral doses of estrogen. If the estrogen level is high she may receive testosterone daily. Or a combination of estrogen-testosterone may be used according to the estrogen level and the clinical symptoms.

It is a distinct pleasure to read the slides for the estrogen level on patients who have had a panhysterectomy operation. The slides are "clean and clear" and give one the impression

that the uterus is the "troublemaker" in the genital tract.

To correlate the cervical cytology studies and the pathological study of the cervix with the beta-glucuronidase study of Kasdon et al.[6] gives further help in the diagnosis of malignancy of the cervix.

GYNECOLOGIST-CYTOLOGIST

Cervical cytologists who have been studying Papanicolaou smears for eight years or longer realize that a small percentage of some cells are very difficult to interpret, but the great majority of cells can be interpreted with a high percentage of accuracy.

Some years ago, with Frederick H. Falls as the senior author, it was presented that one of the best ways to know what questionable cells were, was to take the cells out and see what they look like.[5] When a patient has such cells and there is another reason for surgery, such as a uterine prolapse, a panhysterectomy can be done and the exact origin of the cells found grossly or microscopically and complete knowledge of the case obtained. Thus the gynecologist who is a cytologist does his own surgery and can open the uterus immediately upon its excision from the body. He examines the fresh surgical specimen grossly and within a few days has the pathological slides to help him know exactly what the cells in question were.

Compare this to the ordinary laboratory cytologist who may not receive a pathological report for weeks or months after having studied questionable cells. By that time the cytologist has forgotten the case and upon re-studying the case may sometimes wonder why the cells were questionable at the specific time. If you have trained many technicians in reading smears you have probably had similar experiences.

It then appears that the person who takes the patient's history, examines the patient, takes the smears, reads the slides, performs surgery on the patient, studies the pathology, and supervises radiation therapy is the person who contributes the greatest service to the patient with a preclinical uterine malignancy. This should give the best service to the individual patient and it should give the highest possible cure rate in the total number of patients treated. This is the most scientific method of caring for the preclinical carcinoma of the uterus.

SUMMARY

Cervical Cytology Study includes an aspiration and scraping of the cervical os after a complete pelvic examination has been done. A small amount of pHisoHex® lubricant is used. The punch biopsy is becoming obsolete because it is unfair to the physician and the patient.

Some general practitioners do not do complete pelvic examinations on their patients but many general practitioners and some gynecologists are using cervical cytology studies to help them in their diagnoses. The discovery of Stage 0 carcinomas of the uterine cervix gives the greatest hope for the highest cure rate in uterine malignancies.

The gynecologist-cytologist should give the most efficient service to the patient with a preclinical uterine malignancy.

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ACTH and Cortisone in the Treatment Of Ulcerative Colitis

Factors underlying the basis for the use of ACTH or cortisone in the treatment of ulcerative colitis have been the occasional occurrence of erythema nodosum and arthritis as complications, as well as the finding of low values for urinary ketosteroid excretion.

Cortisone therapy may produce a rapid subsidence of fever, a gain in weight with a return of appetite and a restoration of the erythrocyte sedimentation rate to normal. Diarrhea ceases promptly or subsides gradually. Erythema nodosum and arthritis rapidly disappear. Roentgen and sigmoidoscopic evidence of healing lags behind clinical improvement and is seen only if the remission induced lasts a long time.

The type of patients who appear to respond best to ACTH or cortisone are:

(1) Those with the acute fulminating disease,

(2) Badly debilitated individuals,

(3) Those whose total circulating eosinophils are low and,

(4) Those with erythema nodosum and arthritis.

These agents do not cure the disease any more than insulin cures diabetes. Emotional factors should be searched for and handled after the patient begins improving. The dosage should be gradually reduced to maintenance levels.—Thomas E. Machella, M. D., Philadelphia: *Maryland State M. J.*, 3:547, October, 1954.

Ballistocardiography in Office Practice*

ALEXANDER C. MINELLA, M. D.

THIS report is based on approximately 200 ballistocardiograms taken on private patients in the department of internal medicine and cardiology and some referred from other departments. I wish to emphasize ballistocardiography in practice. No attempt is made to theorize on the many controversial sides of this subject.

Ballistocardiography demonstrates Newton's third law of motion, namely, for every acting force there is an equal and opposite reacting force. The ballistocardiograph records the movements imparted to the body by the forces associated with the contraction of the ventricles. It was first described in 1877 by Gordon.[1] Starr[2] gave it practical application. Dock[3] and Mandelbaum[4] have added much to correlate the various patterns with cardiovascular pathology.

The ballistocardiogram can be used as a rough measure of cardiac output. However, there is some controversy on this subject. It probably gives a better picture of the "force of the heart." It demonstrates the functional status of the myocardium. Starr and his co-workers[5] indicated that the ballistocardiogram is more closely related to the heart's force than to its output.

There are many types of apparatus available for recording the ballistocardiogram. The most practical for routine office use is the Dock Model. In this study, the Dock Model, portable, electromagnetic type was used. Electrical equalization was effected by a 20 microfarad capacitor. It was easily hooked to a General Electric string galvonometer electrocardiograph. A firm board-covered bed was used. The shin bar was placed just below the knees. Electrocardiograms and ballistocardiograms were taken on all of the 200 patients.

The normal ballistocardiogram has many variations. The limits of normal have not been established. Standardization in ballistocardiography is not as easily done as in electrocardiography. A method we have used is to allow a 100 gram weight to fall through a fixed distance and strike the subject's foot thus delivering a blow of constant force to the subject's body. A ballistic pattern of this force is taken for each subject at least once and often several times during the taking of the ballistocardiogram. The difficulty with this type of standardization is that the pattern of the foot blow is not always the same in the same subject.

In the cases under discusion here, no quantitative measurements were made. The ballistocardiogram was studied only from the qualitative viewpoint. The normal ballistocardiogram usually has the configuration as shown in figure 1 which is from a normal 24 year old white female.

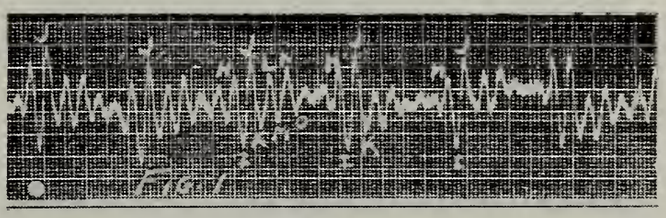


Figure 1

The various waves of the ballistocardiogram are labelled H, I, J, K, L, M, N, O. The waves we know most about are H, I, J, K. L. The most accepted theories[5, 6] on the sources of these waves will be presented very briefly in the following paragraphs.

The H wave represents the return of blood to the heart and its sudden deceleration by the closing of the auriculoventricular valves and the rise of intraventricular pressure. This represents the beginning of systole and the beginning of the first heart sound. The H wave may be normally low, flat, or high. This wave normally varies the most.

The I wave is downward and is due to the ejection of blood from both right and left ventricles. Blood is ejected from these chambers in a headward direction, and therefore the body is pushed footward. The I wave is not too deep normally, not as deep as the K wave.

The J wave normally is the most prominent upward deflection. It is due to the sudden deceleration of blood as it strikes the aortic arch and the curve of the pulmonary artery. This deceleration exerts a force in a footward direction and therefore the body is thrust headward. Thus, the I and J waves represent ventricular ejection. Abnormalities in form and decreased amplitude of the I and J waves signify a reduced velocity and force of ejection. The vertical amplitude between the trough of the I and

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Submitted March 29, 1954.

peak of the J provides an accurate index of the maximal force developed by the heart in systole.[7]

The I and J ejection strokes show a phasic variation in amplitude with respiration. In inspiration these waves increase in amplitude, and decrease in expiration. In normal young individuals, especially under 35 years of age, the variation is present but not to a great degree. In older individuals and in those with heart disease, the variations in inspiration and expiration are quite marked and at times so marked that the waves are unidentifiable. The grading of the ballistocardiogram as employed by Brown, Hoffman, and deLalla[8] places primary emphasis on respiratory variations. Four grades of abnormality are used:

Grade I. Regularity of complexes is maintained. Amplitude in inspiration is normal and in expiration amplitude is decreased and varies in definitiveness.

Grade II. One half or more of the complexes are abnormal, mainly in expiration. The inspiratory amplitude is somewhat decreased also.

Grade III. The complexes are still identifiable, however abnormalities are present in inspiration and expiration.

Grade IV. All the waves are unidentifiable and of low amplitude.

This grading was used at the beginning of this study. It became apparent that the grading was too limited and strict. Too often a ballistocardiogram would not fit any one grade. I do not believe that a system of grading is possible in our present state of knowledge. We need a considerable amount of correlation between ballistic patterns and known cardiovascular disease before a system of grading can be developed.

The K wave is the result of the systemic circulation. It is downward and follows the upright J wave. It is deeper than the I wave. It is caused by deceleration of blood flow in the descending aorta as it is slowed by the peripheral resistance and as ejection velocity falls off at the end of systole. The K wave denotes the closure of the semilunar valves and the second heart sound.

The L, M, N, O waves are the undulations which follow K. They are thought to be due to the return flow of blood and the diastolic filling of the heart. The significance of variations of these waves, especially the L wave, is not understood as yet. The L wave is frequently as tall as the J wave in an apparently normal ballistocardiogram.[11] In this study such an L wave was found frequently. The L wave occurs with the opening of the auriculoventricular valves.

In this study of 200 private patients the ages varied from 10 to 80 years. The majority were between 41 and 60 years. In this group between 41 and 60 years, more than 50 per cent had abnormal ballistocardiograms using the grading system of Brown, Hoffman, and de Lalla. Almost all the ballistocardiograms of those patients over 60 years of age were in Grade III or Grade IV. Very few of these markedly abnormal ballistocardiograms had corresponding abnormal electrocardiograms. Very few of these patients who had markedly abnormal ballistocardiograms had any clinical evidence of cardiovascular disease. As this became apparent, as was mentioned previously, the grading system was discontinued.

The qualitative pattern in quiet respiration was observed and individual abnormalities of the various waves were noted with no conclusions drawn. It became apparent that an abnormal ballistocardiogram in subjects over 40 years of age had very little diagnostic and prognostic significance. However, an abnormal ballistocardiogram in the relatively young subject was viewed with more importance. Conversely, a normal ballistocardiogram in the elderly was an indication of good functional integrity of the myocardium. More will be brought out later on this point.

CASE REPORTS

The following cases represent patients with a known cardiovascular disease. They are presented to illustrate the extent of the practicability of the ballistocardiogram in diagnosis and prognosis in office practice.

Case I: The patient, a 63 year old Negro male, suffered an anteroseptal myocardial infarct January 30, 1953. He responded to treatment well. At the time of his last electrocardiogram and ballistocardiogram September 25, 1953, he was back driving a taxicab and having an average

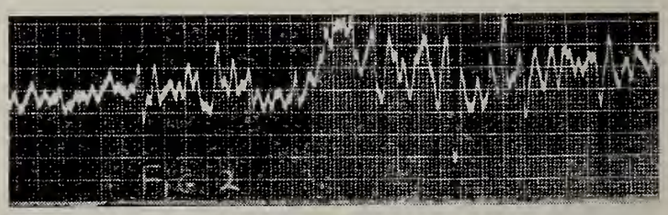


Figure 2

of one anginal attack every week. Figure 2 shows the ballistocardiogram. It is markedly abnormal and is the type seen often in this age group with or without myocardial infarct. Compare this tracing with the following Case 2.

Case 2: The patient is a 64 year old white male, who in an interval of five to six weeks had clinical evidence of two acute myocardial infarctions. In this interval his electrocardiogram showed evidence of both anterior and

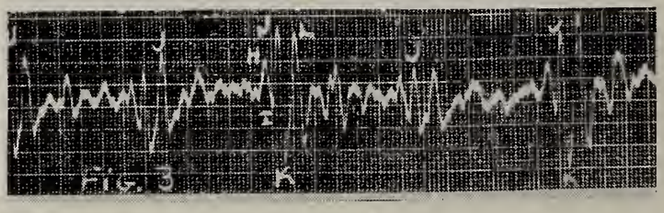


Figure 3

posterior myocardial infarctions. He refused both hospitalization and bed rest at home. He remained ambulatory and continued light work. Follow-up studies were not possible because of his lack of cooperation. However, his most

recent visit to the office, approximately nine months after the acute episodes above, revealed that he needed an occasional nitroglycerin tablet to relieve his chest pain. He was still working and there was no evidence of cardiac decompensation. The electrocardiogram showed evidence of old posterior and anterior myocardial infarctions and multifocal ventricular premature contractions. A ballistocardiogram is shown in figure 3 taken December 2, 1953. It shows a maintenance of the functional integrity of the myocardium except where the ventricular premature contractions occur when the identifiable waves are smaller. It is remarkable to see this despite the myocardial infarctions and his age.

Case 3: A 52 year old white female with a history suggestive of neurasthenia and coronary insufficiency. Nitroglycerin relieved the chest pain. However, the neurasthenia element was quite marked. The electrocardiogram showed iso-electric T waves in leads I, aVL, V_3 and a

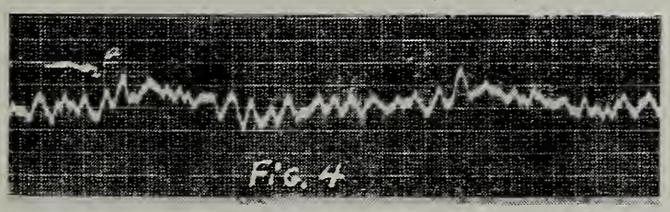


Figure 4

low T wave in V_5. The ballistocardiogram, figure 4, shows low amplitude waves and abnormal. The ballistocardiogram may be used as an aid in evaluating the subjective findings in a neurasthenic individual.

Case 4: A 49 year old white male who has had three myocardial infarctions from 1946 to 1953. There is strong evidence, by fluoroscopy and electrocardiography, that there is a ventricular aneurysm. The ballistocardiograms since his last myocardial infarction have been markedly

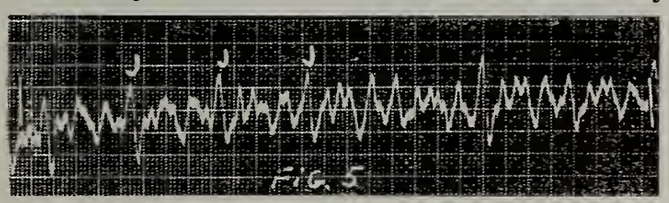


Figure 5

abnormal. The most recent ballistocardiogram is shown in figure 5.

In this ballistocardiogram, four months since his last myocardial infarction, he shows for the first time the appearance of a J wave. However, the ballistocardiogram is markedly abnormal and adds to the poor prognosis. Compare this with Case 2 and figure 3 where the ballistocardiogram adds to a more favorable prognosis.

Case 5: The patient was a 68 year old white male with hypertensive and arteriosclerotic heart disease, auricular fibrillation and in congestive failure. This patient died after several months of

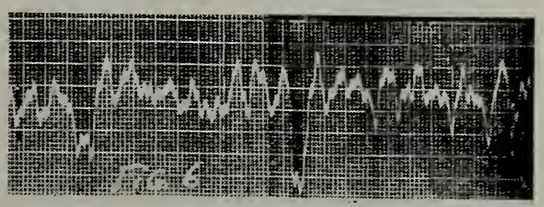


Figure 6

partial response to therapy. His ballistocardiogram, figure 6, is being shown to demonstrate poor functional integrity of the myocardium.

Case 6: A 45 year old white male who had an acute myocardial infarction in May 1953. No ballistocardiogram was taken at that time. A ballistocardiogram taken in January 1954 is shown in figure 7. The patient is relatively

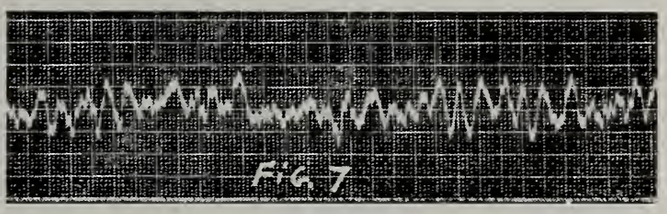


Figure 7

young and therefore the ballistocardiogram is of more significance. It is of low amplitude and all complexes are abnormal. This should help in defining the quantity of activity allowed and the prognosis.

Case 7: A 43 year old white female who had an acute anteroseptal myocardial infarction in September 1953. The ballistocardiogram at that time was markedly abnormal. The ballistocardi-

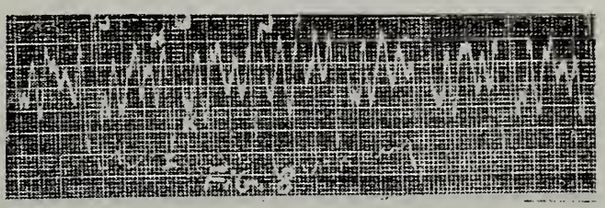


Figure 8

ogram, 18 weeks later, figure 8, shows a remarkable reversion to almost normal. This adds to a more favorable prognosis.

Case 8: A 64 year old white male who was referred for an electrocardiogram. A history with the request revealed that the patient had hypertension and frequent attacks of angina pectoris. The electrocardiogram showed a left bundle branch block which had been present

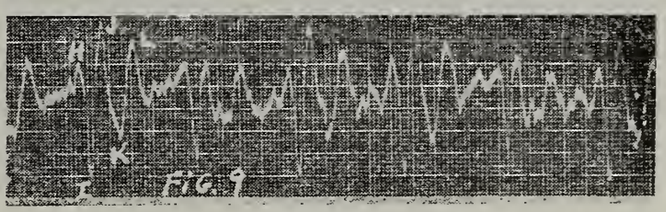


Figure 9

previously. The ballistocardiogram is shown in figure 9. We see regularly occurring waves with a deep I, a tall and wide J wave with a notched downstroke, a deep widened K, and a tall widened L. It is an abnormal tracing.

Case 9: A 61 year old white male with hypertensive heart disease who suffered an acute posterior myocardial infarction. A ballistocardi-



Figure 10

ogram, figure 10, was taken at that time. It is being presented to show the lack of specific pattern. The waves are bizarre and unidentifiable.

Case 10: A 47 year old white female. There are no symptoms referrable to the cardiovascu-

lar system. However, roentgenograms for heart size show moderate enlargement of the left ventricle. The electrocardiogram shows an electrical axis of minus 20° and a low T wave in aVF. The ballistocardiogram is shown in figure

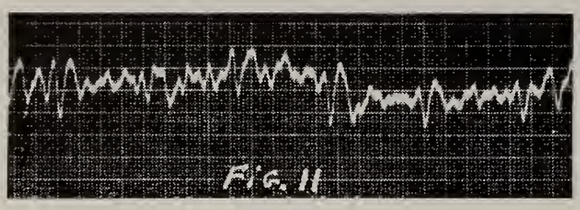


Figure 11

11. It shows low amplitude and abnormal waves. This type of patient should be checked regularly from the cardiovascular viewpoint without producing a cardiac neurosis.

Case 11: A 41 year old white male who suffered an acute anterior myocardial infarct in September 1952. He now has an average of one to two anginal attacks every week, promptly relieved by nitroglycerin. The most recent elec-

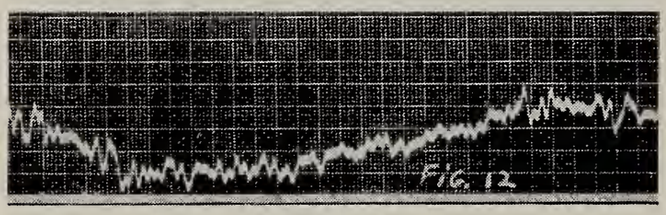


Figure 12

trocardiogram of September 1953 showed only a low T in aVL. The ballistocardiogram taken at the same time, figure 12, one year after the myocardial infarct, is markedly abnormal.

His most recent ballistocardiogram, four months later, figure 13, shows a marked improvement.



Figure 13

The waves can be identified, although they vary in size. The smaller complexes indicate a weaker force of the myocardium.

Case 12: The patient is a 33 year old white female who presented herself with a nodule in the right lobe of the thyroid, extreme nervousness, fine tremor of the hands, a rapid heart rate with loud, booming heart sounds and a basal metabolic rate of only +4 per cent. The ballistocardiogram is presented in figure 14. The

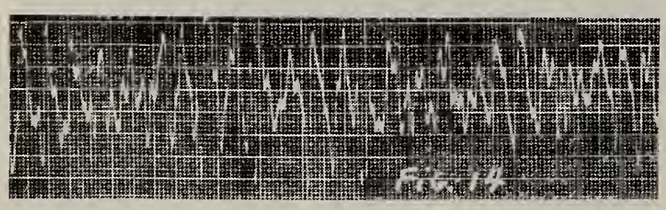


Figure 14

waves are tall with a wide notched J wave. The waves are difficult to distinguish because of the fast rate. The important point revealed is the tall and wide waves. This is a consistent finding so far in hyperthyroidism. Frankel and Rothermich[12] state that this increased amplitude is so constant in hyperthyroidism that its absence in the ballistocardiogram should cast doubt on the diagnosis.

COMMENT

This report is based on approximately 200 cases. Certain temporary viewpoints can be drawn. I wish to reiterate that it is the purpose of this report to aid in revealing the extent of usefulness of the ballistocardiogram in office practice.

Ballistocardiographic abnormalities are very common—over 50 per cent—in individuals over 40 years of age without any apparent cardiovascular disease. In these cases, the ballistocardiogram cannot as yet be used in the diagnosis or prognosis of cardiovascular disease except when it is found normal. In the elderly, especially in those over 50 years of age, a normal ballistocardiogram indicates good myocardial force. Conversely, an abnormal ballistocardiogram in individuals under 40 years, and especially under 30 years, has an unfavorable prognostic significance.

The ballistocardiogram is also useful in following the course of the patient who has had a myocardial infarct. If the precoronary ballistocardiogram was normal, or almost normal, the postcoronary serial ballistocardiograms can be used as a guide for the future activity of the patient. The return to normal of the postcoronary ballistocardiogram could be used as an index of favorable prognosis. It would allow for increasing the physical activity of the patient. When satisfactory ballistocardiographic recovery following myocardial infarction has finally been reached, the physician may feel secure in encouraging the patient to return to full activity. When the ballistocardiogram shows persistent marked abnormalities, the outlook for functional recovery of the myocardium is not good.[10]

SUMMARY

The ballistocardiogram can be of practical use in office practice. The portable Dock Model ballistocardiograph is not expensive and is very practical. It would be of great advantage if the entire apparatus were in one piece instead of two movable ones. The acceleration ballistocardiograph as described by Elliott, Packard, and Kyrazis[13] has the advantage of being one piece and can be used with the ordinary bed.

The ballistocardiogram is significant if abnormal in individuals under 40 years of age and if normal in individuals over the age of forty or fifty years. The ballistocardiogram can be used as a guide in prognosis and therapy in post infarction cases. The normal variations in the ballistocardiogram still need to be deter-

mined. Many more studies need to be undertaken by the clinical investigator and especially by the practitioner.

Acknowledgment: I wish to express my deep appreciation to Mrs. Mary Feely, R. N., who worked very diligently in the taking of the records and in the preparation of this report. I wish to thank also Mrs. Viola Glossner for her stenographic help.

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Treatment of Status Asthmaticus

Status asthmaticus is a medical emergency that must be met with definitive therapy. At least 2,000 deaths directly attributable to bronchial asthma in the United States each year testify to its seriousness. It is true that the mortality rate from asthma has fallen in the past 20 years, but this is for the older patients. In those between the ages of 15 and 24, there has been an actual increase in deaths.

Treatment of status asthmaticus has consisted of many combinations of bronchodilators, oxygen, parenteral fluids, expectorants, and sedatives. With the introduction of steroids, the concept of the general adaptation syndrome and alarm reaction, the discovery of the decrease in circulating eosinophils, and the inhibition of the antigen-antibody relationship after ACTH administration, it soon became apparent that an important group of drugs had been found.—Everett H. Johnson, M. D., Turlock, California: *Wisconsin M. J.*, 53:537, October, 1954.

KEEPING UP WITH MEDICINE

• FROM THE STANDPOINT of social welfare, there should be a greater concentration upon developmental diagnosis to be able to make a real appraisal of normality.

* * *

• ILLNESS in a child is an emotionally traumatic experience to both the young patient and his parents. The physician in this instance can neither be parental, familial, or completely objective. His major concern should be to strengthen the parent-child relationship. This is of the utmost importance to the security of the patient.

* * *

• CHILDHOOD schizophrenia is a disorder in the regulation of the maturation of all basic behavior processes. It must be regarded as a biological process determined before birth.

* * *

• BRAIN INJURY is sometimes not easily distinguished from some of the hereditary or familial types of mental defect but the distinction must be made for the purpose of treatment and education.

* * *

• CEREBRAL PALSY is responsible for as large a number of crippled individuals as any single condition except poliomyelitis. In contradistinction to an epidemic disease such as poliomyelitis, cerebral palsy is the result of many causes and so the number of cases per year in any given community is not predictable.

* * *

• WELL OVER 50 per cent of children at some time have a functional heart murmur. The treatment is reassurance.

* * *

• DRUG THERAPY of the epileptic child calls first for phenobarbital. This is relatively cheap and requires little supervision. Dilantin® is more effective and is not a sedative. Mesantoin® is at times more effective but has a sedative effect and in rare cases injures the blood. Hence, supervision and periodic blood examination are necessary.

* * *

• TUBERCULOSIS may take a foothold in the human body either when physical factors first pave the way or when psychological factors prepare the ground for the TB bacilli.

* * *

• IN SPITE OF the fact that emotional disturbances do precipitate or enhance allergic reactions, it has not been shown objectively up to this time that true allergic manifestations are initiated other than by contact with or invasion into the body by an offending allergen.—J. F.

Pyoderma Gangrenosum in Association with Chronic Ulcerative Colitis*

HENRY A. BRUNSTING, M. D.

PYODERMA gangrenosum is a fulminating ulcerative disease of the skin, which appears in individuals primarily affected with chronic ulcerative colitis.

The occurrence of infectious gangrene of the skin in association with debilitating systemic disease, especially dysentery, has been recorded in the literature, with considerable confusion in nomenclature, during the past century.

Brunsting, Goeckerman and O'Leary,[1] in 1930, were the first to describe this syndrome in detail, suggesting the term pyoderma gangrenosum in a report of five patients, four of whom had chronic ulcerative colitis, and one chronic empyema. Subsequent to this original report, numerous patients with this disorder have been presented before dermatologic societies and case reports recorded in the literature.[2] Divergent opinions have resulted from attempts to correlate this syndrome on the basis of a study of one or a few patients.

The incidence of skin manifestations in association with chronic ulcerative colitis is not uncommon. Bargen[3] reported that it occurred in 2.4 per cent of his series of 693 patients. Felsen,[4] in a study of 1072 patients with chronic ulcerative colitis, stated that involvement of the skin occurred in 2.9 per cent. Ricketts and Palmer[5] reported an incidence of 10.7 per cent, in a series of 206 patients.

The skin disorder which occurs may be variable in character and severity, and usually involves the extremities and body. The cutaneous pattern may be represented by furunculoid lesions, erythema multiforme, exanthematous eruptions, erythema nodosum or extensive fulminating ulcerative pyoderma. Involvement of the skin may precede the development or recognition of the underlying systemic disorder, the bowel signs and symptoms appearing at a later date. Not infrequently the cutaneous manifestations may assume greater clinical significance than the underlying systemic disease.[6]

There appears to be a definite parallel between the activity of the skin lesions and the state of the underlying debilitating process. It has been emphasized previously[1] that patients suffering from this disorder are in a hypersensitive state. They frequently develop cutaneous lesions following simple trauma of a hypodermic injection. Additional evidence of this hypersensitive nature is noted in their reaction to various medications, such as following ingestion of the iodides, sulfonamides and carbarsone. The association of periarthritic manifestations has been reported as high as 17 per cent,[3] and transient bouts of episcleritis may occur.

The Author

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CLINICAL DESCRIPTION

In the early stage of the disease, the patient may present crops of small, discrete pustules surrounded by an inflammatory areola. The center of the pustule may soften, the overlying skin turning blue and then break down. The lesion either undergoes spontaneous involution or extends peripherally to coalesce with others adjoining to form a larger superficial ulcerative process. The resulting ulcers may be single or multiple, and may eventually involve extensive areas of the skin of the extremities, thoracic or abdominal wall. The borders of the ulcer are well defined and have a distinctive blue color, extending peripherally in a serpiginous configuration. There is extensive undermining and necrosis of the subcutaneous tissue, the epidermis extending over the crater of the lesion in a ragged, irregular fashion. The base of the ulcer is covered with a mucopurulent exudate and tissue debris. Dependent upon the stage of activity, granulations appear and are digested away.

Healing occurs by epithelial outgrowths from the outer zone, with resulting thin atrophic scars and brownish pigmentation, characteristically outlining the original serpiginous configuration.

BACTERIOLOGY

The relationship of this fulminating ulcerative process of the skin to any specific bacterial flora has never been proven. Culture of material from the ulcers usually reveals Staphylococcus albus and Streptococcus hemolyticus, which are frequently found on normal skin or in types of cutaneous infections which respond readily to ordinary antiseptic and antibiotic therapy. Cul-

*Presented at the American Academy of Dermatology and Syphilology, Chicago, Illinois, December 9, 1953.

Submitted February 4, 1954.

ture of a fresh pustule is frequently sterile. Blood cultures are consistently negative.

HISTOPATHOLOGY

The results of histopathologic study are not specific, and in general reveal an inflammatory process, the type and degree of reaction dependent upon the stage of the disease. The early pustular and later ulcerative phase is characterized by a dense central infiltration of polymorphonuclear leukocytes merging with a peripheral zone of lymphocytes. The elastic tissue in the area of the abscess is destroyed. Changes in the blood vessel wall are not marked. Cocci are easily demonstrated at the periphery of the process undermining the epidermis.

In the late, or vegetative stage, there is marked irregular acanthosis and hyperkeratosis with eosinophilic leukocytes, lymphocytes, fibroblasts, foreign-body giant cell reaction and pronounced pseudo-epitheliomatous hyperplasia. Cocci are not demonstrated as easily as in the acute ulcerative phase. Healing occurs with marked scarring and destruction of practically all accessory cutaneous appendages.

DIFFERENTIAL DIAGNOSIS

The appearance of crops of pustules, with a circumscribed inflammatory areola, may suggest the diagnosis of ioderma or bromoderma to the casual observer. A careful history is essential.

Blastomycosis, sporotrichosis, coccidioidal granuloma and other mycotic infections can be ruled out by inability to demonstrate typical organisms in smear or culture.

The diagnosis of tuberculosis verrucosa cutis, tertiary syphilis and cutaneous ulcers in association with sickle cell anemia can be eliminated by lack of confirmatory evidence. If malingering is suspected, careful observation is necessary to rule out factitial dermatitis.

TREATMENT

There are no standard procedures of management which can be laid down for all patients suffering from this disorder. The therapy for each patient must be individualized. Attention must be directed to certain factors which tend to precipitate the periodic relapses which characterize this syndrome. These include the avoidance of fatigue, intercurrent infection, emotional disturbances and dietary indiscretions. A bland, low-residue, non-laxative, high caloric diet with adequate protein intake and vitamin supplement is essential.

In the acute phase of the disease, the patient must be in strict bed rest. When hypochromic anemia is present, blood transfusions are indicated. The judicious use of the corticosteroids may be of value in selected cases and in patients with an associated polyarthritis. The initial dosage should be low and the medication discontinued gradually. Some patients will manifest the so-called "rebound phenomena" when this type of therapy is discontinued and therefore it should not be employed indiscriminately or as a routine measure.

The introduction of the antibiotics has not materially influenced therapeutic response in this syndrome, which suggests that the bacterial flora is probably not of primary significance. Specific vaccines and serums do not seem to be of value. Bargen[7] maintains that azulfidin® (formerly azopyrin) is the most valuable of all medicaments he has tried. This drug is a combination of salicylic acid and sulfapyridine and was introduced in this country from Stockholm about ten years ago. The dosage is 1 gm. every 3 hours for a few weeks, with gradual reduction. Toxic manifestations are rare.

Local measures in the treatment of the cutaneous ulcers are of value. Prolonged immersion in a sulfur bath consisting of a dilute mixture of precipitated sulfur, sulfuric acid and sodium hyposulphite is beneficial in extensive pyogenic infection. Meleney's zinc oxide paste has been used with some success. Topical use of the antibiotics in the form of a powder, wet dressing or ointment may assist in checking the progress of the ulcerative process.

The efficacy of any local therapeutic measure is in relation to the state of activity of the underlying constitutional disorder.

In resistant and recurrent cases, surgical intervention is indicated before serious complications of the bowel occur. The morbidity and mortality risk in this extensive surgical procedure has been materially reduced since the introduction of antibiotic therapy. Ileostomy and subsequent colectomy is indicated in patients who have repeated exacerbations and fail to respond to adequate medical management.

In summary, the treatment of pyoderma gangrenosum is the treatment of the underlying debilitating systemic disease.

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Evaluation of Surgery in Hypertension*

JOSEPH L. DeCOURCY, M. D., and CORNELIUS B. DeCOURCY, M. D.

THE importance of the problem of hypertension is indicated by estimates that, through effects on the brain, kidneys and heart, this condition is responsible for an annual mortality of about 200,000 persons in the United States.

In recent years there has been a notable revival of interest in the surgical treatment of hypertension. Four methods have been used: sympathectomy, total adrenalectomy, subtotal adrenal resection, and a combination of sympathectomy with one of the other two procedures.

For more than two decades, subtotal bilateral adrenalectomy has been employed at the DeCourcy Clinic,[1] with results which lead us to consider it the method of choice in selected cases of hypertension for which surgery is indicated. Recent published reports of the use of other operative procedures appear to confirm this view, as we are obtaining equally good results without the mortality or morbidity associated with sympathectomy, total adrenalectomy or the combined operations.

PATHOGENESIS OF HYPERTENSION

Despite much clinical and laboratory investigation, the etiology of so-called "essential hypertension" remains uncertain. Current opinion is departing from the concept of the kidney as the primary offender. Humoral agents are receiving much attention as possible causative factors. A recent review of this subject by Friedland states that no less than 12 of these may deserve further investigation, though general opinion assigns them to a sustaining rather than a primary role. Friedland adds that "The possibility remains, however, that adrenocorticogenic influences comprise an important *link* in the maintenance of hypertension."

At a symposium on hypertension, held under the auspices of University of Minnesota,[2] several speakers referred to the probable role of the adrenal cortex. For example, Selye, on the basis of both animal and human experimentation, stated that "Increased corticoid production undoubtedly plays an important part in the genesis of certain types" of hypertension and referred to the effect of stress in increasing corticoid production. Wolf and Wolff also reported experience indicating that certain forms of emotional conflict elevate the blood pressure in both hypertensives and normotensives.

RESULTS OF SURGERY AS REPORTED IN THE LITERATURE

The operation most widely used in hypertension up to the present is sympathectomy; but the unsatisfactory results are widely recognized.[3] Evelyn and his associates[3] analyzed the records of all ward patients on public services who were subjected to sympathectomy for hypertension at the Massachusetts General Hospital from 1935 to 1947. Five years after the operation, the blood pressure was normal in only 8 per cent and significantly lower than before surgery in an additional 13 per cent; while in 52 per cent there was no significant decrease and the remaining 27 per cent were dead.

Patients with a high diastolic type of hypertension, who had failed to respond to thiocyanate therapy, were chosen by Davis and his co-workers for sympathectomy. The results were considered unsatisfactory, and 12 of the series of 25 patients were dead within two years. Four of these deaths occurred immediately.

The adrenal glands resemble the thyroid in their capacity to carry on their physiological functions with a surprisingly small percentage of the tissue which is normally present. Complete adrenalectomy, however, is accomplished by a high mortality even when followed by replacement therapy. Thorn and his associates performed this operation in 15 cases, chiefly of very severe and complicated hypertension. Cortisone was administered postoperatively; but there was a mortality of almost 50 per cent within three months.

All available evidence indicates that subtotal adrenalectomy in which more than 90 per cent of the glandular tissue is removed also involves a prohibitive mortality. In 14 cases reported by Wolferth,[4] the quantity resected appears to have considerably exceeded this figure, as the author expresses the opinion that 5 per cent or less of the adrenals should be left *in situ*. The mortality in this series was 29 per cent.

Very recently, Jeffers and his associates[5] have published their results in 99 cases of hypertension treated surgically. In the majority of these cases (70 per cent) sympathectomy was performed in conjunction with either total or subtotal adrenalectomy. As a rule, 95 per cent or more of the adrenal tissue was removed. Despite

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*From DeCourcy Clinic, Cincinnati, Ohio.
Sumbitted February 8, 1954.

postoperative replacement therapy, the mortality was 24 per cent. Evaluation of the results in the surviving patients cannot be regarded as definitive in a condition such as hypertension, which calls for a prolonged follow-up, inasmuch as 41 per cent of the series had been under postoperative observation for brief periods (0 to 6 months) and only 23 per cent had been followed for more than 18 months.

SUBTOTAL ADRENALECTOMY AT THE DeCOURCY CLINIC

In our early bilateral resections of the adrenals for the treatment of hypertension, from two-thirds to three-fourths of each gland was removed in two stages. The interval between stages was two weeks. Our experience led to the conclusion that a longer period between the stages gave better results and the interval was increased to three months. We also increased the percentage of adrenal tissue removed. In most cases we have found that resection of about four-fifths of each gland is sufficient; but in certain instances the quantity removed is as much as nine-tenths. The indications in the individual case determine the optimum amount which should be resected. It is evident that normal function is maintained when 10 per cent of the glandular tissue is left, as no form of replacement therapy has been required in any of our cases.

In our early series of 10 patients subjected to the procedure employed at first, there was a mortality of 2. The method which experience proved to be advisable, as has been described, has now been employed in 25 cases. All patients selected for surgery suffered from malignant hypertension, with blood pressure levels of from 240/120 to 260/140. In every instance, medical treatment had been given a thorough trial, usually for from four to six months, and had proved ineffectual. The mortality in the series of 25 was nil.

All our patients have been kept under careful and prolonged observation since they were operated upon. The subjective results have been excellent in all patients. There has been prompt relief of such symptoms as headaches, and dyspnea, accompanied by a surprising sense of well-being and often by an increase in weight. This relief has usually proved permanent. Judged objectively, the results have been less favorable. The blood pressure was significantly reduced in approximately 75 per cent of the patients; but it often returned later to nearly the same, or the same, levels found prior to surgery. The initial reduction has been maintained in some cases. however. Our records show patients whose blood pressure returned to normal after subtotal adrenalectomy, as performed at this clinic, and has continued to be normal during follow-up periods as long as twelve years.

The long-range mortality has been somewhat better than in patients with comparably severe hypertension treated medically; and appears. from published figures, to be markedly better than in those who have undergone other operative procedures.

GROUP MEDICINE AND CONSULTATION

We are of the opinion that an important factor in our favorable results is the close cooperation of a carefully integrated team for good results in adrenal resection.[5, 6] For physicians in private practice, this need can be met by consultation with thoughtfully chosen specialists. This is in accord with ethical medical custom of long standing. Final decisions should, however, rest with the attending physician.

Closely connected with this subject is the problem of lengthy hospitalization and the overcrowded condition of our hospitals.

CONCLUSION

1. We believe that surgery should have a limited place in the treatment of hypertension. It should be confined to severe, carefully selected cases.

2. Increasing evidence of the importance of the adrenals in producing or maintaining hypertension, and published results of various operative procedures, indicate that subtotal adrenalectomy has distinct advantages over any other surgical treatment yet proposed.

3. Not more than 90 per cent of the adrenal tissue should be removed and in many cases a smaller proportion is adequate.

4. Adrenal resection gives optimun results when done in two stages, separated by an interval of three months.

5. The procedure described offers hope of symptomatic relief in practically all cases, a permanent lowering of the blood pressure in some instances, and prolongation of life in severe cases of malignant hypertension which do not respond to medical management.

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Subdural Effusions Complicating Bacterial Meningitis

A Pediatric Review

EDWARD C. MATTHEWS, M. D.

WITH the recent advent of potent antibiotics and chemotherapeutic agents, it has now become possible to treat patients in the early stages of acute bacterial meningitis with the expectation of a high survival rate. It has therefore become increasingly important to recognize and properly treat the complications of bacterial meningitis so that the surviving patient may be, insofar as possible, free of any incapacitating residuum of his disease. One such complication for which there is a satisfactory treatment is subdural effusion.

Subdural effusions have long been recognized as a complication of bacterial meningitis but their frequency was formerly relatively low and their importance relatively small because few patients lived long enough to develop them.

PATHOGENESIS

The pathogenesis of the effusions has not been clearly defined. Arnold and Gitlin have demonstrated that the protein in the effusions is blood protein, and the consensus of opinion is that infection in the subarachnoid space may so damage the boundary membrane of the arachnoid villi or the arachnoid itself that serum, cells, and occasionally bacteria may pass into the subdural space. As in subdural hematoma the cells in the subdural space are lysed, producing a solution of high osmotic pressure which draws in fluid from the subarachnoid space thus gradually enlarging the subdural effusion.

Smith, Dormont, and Prather have pointed out that the blood supply to this area is meager, consisting only of a capillary network of vessels in the dura, the arachnoid being free of both blood vessels and lymphatics, and, for this reason, resorption of the fluid is slow. If the effusion is of long standing, it may become encapsulated in a fibrous membrane. The effusion itself thus constitutes a space occupying lesion within the skull and the pressure may produce damage or irritation to the adjacent brain, while the adherent membrane may inhibit expansion of the growing brain. It is therefore a matter of considerable importance that such an effusion be removed.

ETIOLOGIC FACTORS

Presumably a subdural effusion might complicate any form of bacterial meningitis, but it has been observed most frequently in infections caused by H. influenzae, pneumococcus, and meningococcus. The age incidence of the occurrence of subdural effusions shows a high preponderance in infants under one year of age which Smith et al. interpret as simply paralleling the high incidence of bacterial meningitis in this age group. However, McKay, Ingraham, and Matson present evidence indicating that age itself may play a factor in the development of subdural effusions and that infants under one year of age with meningitis are more prone to develop effusions than are older children.

Submitted August 28, 1954.

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CHARACTERISTICS

The effusions are often bilateral and even when they are found on only one side on the initial subdural tap, they may occur on both sides in subsequent taps. The fluid may vary considerably in amount, ranging from 2 cc. up to 60 or 75 cc. It may be xanthochromic, blood tinged, bloody, or purulent, and it contains elevated amounts of protein but this too varies through a wide range, with a tendency to increase with repeated taps. The protein level in the subdural fluid is uniformly higher than that in the spinal fluid. The sugar content of the subdural fluid may fluctuate widely or it may be normal.

Culture of the subdural fluid is positive for the causative organism of the meningitis in some instances even when the spinal fluid culture is negative. For this reason Smith et al. recommend that subdural taps be done routinely on all infants with meningitis who have received therapy prior to their admission to the hospital in the hope of obtaining a diagnostic positive culture.

There are a variable number of cells in the subdural fluid, usually in the range of 200 to 400 and predominantly polymorphonuclears, but the cell count may be much higher. By way of comparison, it is of note that Ingraham and Matson found only a few drops to 1 cc. of clear colorless fluid of low protein content in the subdural space of normal individuals.

The actual incidence of subdural effusions occurring in children with meningitis is not known because subdural taps have for the most part been performed only in those in whom there was

a manifest clinical indication to do the taps. However, Smith et al. performed a number of routine subdural taps in children recovering from meningitis in whom there was no particular clinical indication for the procedure. In her series of 43 patients under 2 years of age with meningitis, 20 were found to have subdural effusions, and in 9 of these, subdural effusion was found on routine tap while there were 11 with effusion in which there was some definite clinical indication for performing the subdural tap. Whether subdural effusions which do not manifest themselves by clinical signs have clinical significance in the eventual prognosis of the case is problematical.

SYMPTOMS

In clinical practice routine subdural taps in children with bacterial meningitis are probably not indicated, but they should be done if any of the following clinical signs develop: (1) fever failing to show a good response after 2 to 3 days of adequate therapy, (2) focal neurologic signs, (3) generalized convulsions after an initially good response to therapy, (4)persistent vomiting, (5) an enlarging head, (6) a bulging fontanelle not relieved by lumbar puncture, and (7) the clinical impression that the child is not doing as well as he should. Arnold describes, in addition, an area of erythema, local heat and edema in the region of the anterior fontanelle in two cases in which the subdural fluid was found to be purulent.

TREATMENT

When subdural fluid is found, its removal is indicated. McKay et al. believe there is a risk involved in removing at one time large quantities of fluid and they therefore recommend that a maximum of 15 to 20 cc. be removed at each subdural tap, but Smith et al. have removed large effusions with a single tap and have observed no untoward effects. Once a subdural effusion has been discovered, it is recommended that subdural taps be done daily or every other day. If the adverse clinical signs disappear and no more fluid can be obtained after several days of such therapy, the taps may be discontinued and no further therapy for the effusion is indicated. If, on the other hand, fluid is still obtained in significant amounts after 7 to 10 days of subdural taps, surgical intervention is indicated. In children in whom the fontanelle is closed, if subdural effusion is suspected, the initial diagnostic procedure must be a burr hole.

In general, surgery should be delayed until the patient is fever-free and the cultures of the subdural and spinal fluid are negative. Surgery consists of making burr holes first, and then if a membrane can be demonstrated, craniotomy is performed for its removal. If membranes are present bilaterally, usually an interval of 7 to 10 days is allowed to elapse between craniotomy on the two sides. Antibiotic and anticonvulsant therapy should be maintained postoperatively, the latter for at least two weeks.

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Problems and Prospects in Virus Immunization

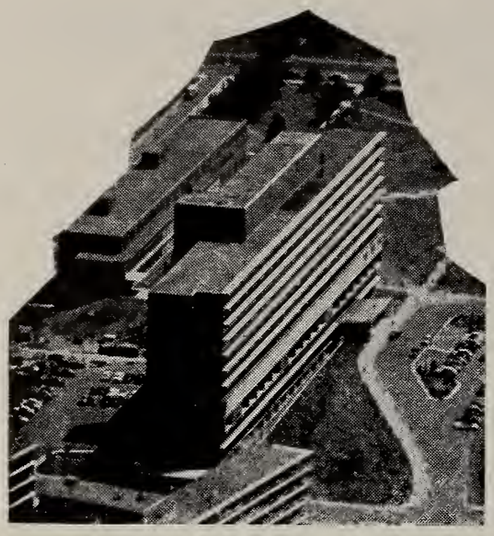
In view of the current widespread interest—and not a little confusion—concerning the mass polio vaccination program, it seems worthwhile to review briefly some of the pertinent facts about virus vaccines.

A survey of the technical literature of 20 years ago shows that a number of the leaders in the virus field were expressing doubt and skepticism regarding the utility of killed viruses as antigens. Their convictions were such that, in commenting on the occasional report of successful antibody stimulation by killed vaccines, some of these leaders wondered out loud if all of the virus in these successful vaccines had actually been killed.

In the intervening years, much has been learned about viruses and the methods of propagating them, and many new viruses have been discovered, but during this time not much has happened to arouse enthusiasm for killed-virus vaccines. Preparations of this type have been made and used, but almost without exceptions, they have represented one kind or another of compromise with necessity. Few individuals were deluded into the belief that killed-virus vaccines give rise to a quality of immunity comparable to that which follows natural infection.

Misleading as most generalizations are, it is not unreasonable to state that most of the problems and defects of killed-virus vaccines arise out of two fundamental properties of viruses—their small size and the necessity of propagating them in the presence of living host tissues. . . .

There are a few killed vaccines, like those for influenza and mumps, which are relatively rich in virus antigen. They are rich because, by means of high speed centrifugation or precipitation methods, these viruses can be recovered from the allantoic fluids of the chick embryo comparatively free of extraneous host tissue. These two viruses attain high titers in the allantoic fluid of the chick embryo, and they also are large when compared with polio virus. Thus they lend themselves to practical methods of concentration. But they are exceptions.—Floyd S. Markham, Ph. D., Pearl River, N. Y.: *J. Iowa State Med. Soc.*, 44:505, November, 1954.



A Case Record

From The University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

Burr M. Hathaway, M. D., President

Presented by Arthur G. James, M. D., and Emmerich von Haam, M. D. Edited by E. von Haam

PRESENTATION OF CASE

A WHITE FEMALE, aged 75, was admitted to the Ohio State University Hospital complaining of shortness of breath, weakness, anorexia and right-sided chest pain. She was moderately disoriented and gave an inadequate history. She had had a large but asymptomatic mass in her neck for approximately 20 years. Two months prior to admission she started to complain of right-sided chest pain and a cough productive of about a cupful of white "phlegm" daily. She had fever and increasing difficulty in breathing. She had been hospitalized for 4 weeks in another hospital just before her admission to University Hospital. The past history could not be elicited due to the confused state of the patient.

Physical Examination: Physical examination on admission revealed a patient in moderate respiratory distress. The temperature was 100°F., the pulse 100 per min., the respiratory rate 36 per min., the blood pressure 138/78. The turgor of the skin was poor. A trilobed mass in the anterior portion of the neck was thought to be an enlarged thyroid gland; the left lobe measured 6 by 3 in., the middle lobe 1 by 2 in., the right lobe 2 by 4 in. The chest was dull to percussion with absent breath sounds at the right base. The right leaf of the diaphragm was fixed. The left lung was clear to percussion and auscultation and the left diaphragmatic leaf was movable. The liver was enlarged and tender. There were no palpable lymph nodes. There was a right direct inguinal hernia with a truss in place.

Laboratory Data: Urinalysis on admission revealed a specific gravity of 1.027, a *p*H of 5.5, a protein content of 10 mg., and a trace of sugar; the microscopic examination revealed 1 to 3 white blood cells, 0 to 1 red blood cell and many epithelial cells per high power field. Smear and culture of the urine were negative for acid-fast organisms. The red blood cells in the peripheral blood numbered 4.29 mil., the hemoglobin content was 10.8 gm., the white blood cells numbered 36,100 with a differential count of 82 per cent neutrophils and 18 per cent lymphocytes. The prothrombin time was 60 per cent of normal and on a repeated determination was 106 per cent. The blood urea nitrogen was 34 mg., rising to 96.5 mg. on the eighth hospital day; the blood sugar 121 mg., and the total serum protein 6.4 gm.

On the eighth hospital day the CO_2 combining power was 63 vol., the blood chlorides 95 meq., the sodium 148 meq., and the potassium 4.7 meq. The total proteins determined just prior to expiration of the patient were 4.7 gm. with an albumin of 1.6 and globulin of 3.1. Fluid obtained by thoracentesis had a protein content of 3.5 gm. with an albumin of 2.5 and a globulin of 1.0; no malignant cells were seen. The interpretation of two electrocardiographic tracings was that the patient had a left axis deviation and probably suffered from left ventricular strain.

Roentgenographic Findings: On admission, posterior-anterior, right lateral chest films and barium swallow were interpreted as probable metastatic involvement of the right chest, marked pleural effusion and a large thyroid struma with tracheal compression and esophageal shift. Flat plate of the abdomen showed gastric dilatation and soft tissue shadows in both subdiaphragmatic areas suggestive of subdiaphragmatic disease.

Hospital Course: Two thoracenteses done on the first and second hospital days removed 500 cc. and 200 cc. of straw-colored clear fluid from the right pleural cavity. PPD (purified protein derivative—tuberculin) and histoplasmin skin tests were negative. On the third hospital day the patient developed acute pulmonary edema with sinus tachycardia. Following the administration

of digitalis, a mercurial diuretic and oxygen and the use of tourniquets, the cardiac status improved. An electrocardiogram showed nodal rhythm of 135 but no subendocardial ischemia. During the first days of hospitalization the patient complained of epigastric pain and the possibility of a peptic ulcer was considered.

On the fourth hospital day a definite mass was palpated in the right upper quadrant and right flank; this mass was movable and very tender. Her stools were semi-liquid, dark brown and gave a 4 plus positive reaction to guaiac test. On rectal examination no masses were demonstrated, but a nodular mass was palpated in the pelvis and thought to be a fibromyomatous uterus. On the tenth hospital day her stomach became quite distended. Roentgenographic examination showed a markedly enlarged stomach filled with air and fluid. It was felt that the gastric dilatation had been caused by swallowing of "nasal" oxygen.

The patient was given penicillin and streptomycin but continued in her febrile state throughout the hospital course, with a fever of 101°F. during the first few days and a rise to 103°F. during the last few days. The patient continued to have respiratory distress throughout her hospitalization. Her condition rapidly deteriorated during the last two to three days and she expired quietly on the twelfth hospital day.

CLINICAL DISCUSSION

DR. A. G. JAMES: Briefly, we have a 75 year old white female admitted and in the hospital for a total of 12 days. Her chief complaints on admission were primarily referable to the respiratory system and consisted of shortness of breath, cough productive of white phlegm, and right-sided chest pain. In addition she had anorexia and was somewhat disoriented. The main physical findings were an enlarged thyroid, dullness in her right chest and evidence of pleural fluid. There was some mention of a right upper quadrant mass. From the chart I could not be sure whether this was a tumor or whether they were palpating an enlarged liver. Other than that her physical findings were not significant. She had a direct inguinal hernia which was apparently noncontributory to her illness.

The laboratory findings were not very significant. She had a blood urea nitrogen which was elevated to 34 mg. As she went along she developed evidence of dehydration and her urea rose to 96 mg. She was not very anemic, but she showed a persistent leukocytosis. The cells that were examined from the centrifuged pleural fluid were thought not to be malignant. Because of the pleural effusion and the cough, sputa were examined and no acid-fast organisms were seen. Her course was one of pulmonary sepsis. She was running a temperature of 100 to 101°F. for the first few days of her admission, which gradually rose during the last days before death to between 104 and 105°. It is interesting to note that this rise occurred in spite of the antibiotics she received. In addition to that, her progress notes showed that on about the second day definite signs of cardiac decompensation made their appearance, and I feel that her death must have been on the basis of respiratory and cardiac embarrassment.

ANALYSIS OF SYMPTOMS

It is my opinion that the symptoms this patient presented certainly speak for some primary pulmonic disease. If we are thinking in terms of a neoplasm, we must consider primary carcinoma of the lung. Probably the most common symptom in carcinoma of the lung would be cough, which she had. The second most common symptom would probably be pain in the chest, which she also had. Another common symptom, probably the third most frequently occurring, would be hemoptysis, which she did not have. So that certainly she had symptoms that would point to a primary pulmonic neoplasm. I think that the occurrence of fluid in only one pleural cavity also would suggest a primary neoplastic process of the lungs rather than a metastatic lesion or some cardiac involvement.

If this were to be considered a case of primary pulmonary carcinoma, then she must have had a coexistent large nodular goiter which probably had been present for years and which had been causing no symptoms. However, there may also be another possibility worth discussing. We could postulate that her thyroid gland may have been the sole source of her troubles. She had had the goiter for years, and we know that goiters may remain harmless for years, but that 5 per cent of them will become malignant. That is one reason why nodular nontoxic goiters should be removed in the same line of thinking that a gallbladder with stones should be removed.

One x-ray picture definitely showed some retro-esophageal involvement and you could see the posterior margin of the trachea. Dr. Curtis used to say that the space opposite the sixth cervical vertebra should be no greater than two-thirds the width of this body. In our case this space was a good three times the width of the body, so that this patient had an enormous retrovisceral or retro-esophageal extension of her goiter. Thus we could assume that her illness was on the basis of a nodular goiter which had become malignant and which had metastasized to the mediastinal lymph glands. Bronchial obstruction by an enlarged lymph node would easily explain the pulmonary atelectasis and the pleural effusion could be attributed to pleural implants or parietal pleural involvement.

What are the other possibilities we have to consider in our differential diagnosis? We have to consider any tumor that may originate in

this area. We had a patient a couple of months ago who presented a similar picture and at the time of the operation we encountered an enlarged left lobe of the thyroid gland. However, after that was mobilized we discovered a primary prevertebral tumor which proved to be a leiomyosarcoma and which, we believe, originated in the esophagus. Does anyone else here on the floor have a suggestion as to a possible diagnosis? What else should be considered that would give this picture with the symptoms you have heard in a 75 year old white female?

GENERAL CLINICAL DISCUSSION

DR. J. L. MORTON: Her x-ray pictures were difficult to interpret. The question of whether the transverse heart diameter was enlarged and whether this represented heart failure is extremely difficult to answer because the mediastinal extension of the pleural effusion would increase the size of the heart silhouette. The anterior segment of the upper thorax contained a diffuse homogenous density suggesting an atelectasis. The hilar shadow appeared to be a little fuller and suggested a primary tumor producing segmental pulmonary atelectasis and metastatic spread into the hilum. Her goiter displaced the trachea forward and compressed the trachea and esophagus. There was also some degree of retropharyngeal encroachment. I think it is a case of pulmonary tumor but we must admit the possibilities of carcinoma of the thyroid, lymphoma or thymoma. In summary then, we were confused.

MEDICAL STUDENT: Dr. James, what about the 4 plus guaiac test of the feces and the mass in the patient's right upper quadrant?

DR. JAMES: As I said, in going over the chart I could not be sure whether this was a mass or whether it was a liver which was markedly congested. If she did have a mass and she had a guaiac-positive test, one would consider carcinoma of the colon with pulmonary metastasis. I do not know how one could rule that in or out, but one must mention that as a possibility.

DR. E. M. HARD: I was the only one who felt that mass.

DR. JAMES: What did you think about it?

DR. HARD: It was a definite mass probably 8 cm. in length and somewhat narrower than that.

DR. JAMES: I would venture a guess that it was a fecal impaction of the colon. We have a patient in the hospital right now that's 82 and has a large mass in the left upper quadrant which Dr. Morton thinks is a large colon filled with feces. It does happen in old individuals.

DR. G. J. HAMWI: Dr. James, what about thymoma?

DR. JAMES: Thymoma? Certainly you would have to consider that. However, it would be rare in an older person.

CLINICAL DIAGNOSIS

1. Carcinoma of the thyroid.
2. Metastasis to the mediastinum.
3. Partial pulmonary atelectasis.

PATHOLOGIC DIAGNOSIS

1. Undifferentiated carcinoma of the lung.
2. Metastasis to liver and lymph glands.
3. Chronic bronchitis with bronchiectasis and pulmonary fibrosis.
4. Healed rheumatic heart disease with calcific mitral and aortic valvulitis.
5. Acute duodenal ulcers.
6. Diverticula of the duodenum.
7. Acute hepatitis with hepatic vein thrombosis.
8. Cholelithiasis.
9. Uterine fibroids.
10. Right inguinal hernia.
11. Large colloid goiter.

PATHOLOGIC DISCUSSION

DR. E. VON HAAM: I think that Dr. James presented the case well from the standpoint of differential diagnosis between carcinoma of the thyroid and the lung. The patient was emaciated and had an estimated weight of 110 pounds. Her goiter could be well palpated through the skin. Upon opening the body there was a moderate amount of fluid in the right pleural cavity. The heart was the normal size but definitely showed calcific aortic and mitral valve disease. It was probably the consequence of healed rheumatic fever. I do not believe, however, that this lesion was clinically very evident since the heart as a whole was not appreciably changed in size or configuration.

The left lung weighed 450 grams and consisted of hypocrepitant gray tissue with some black webbing. The right lung weighed twice as much and the upper lobe contained a large mass which measured 10 cm. in diameter and on cut surface showed a friable, soft tissue of reddish gray color. The tumor surrounded the upper lobe bronchus, which could be traced into it. There was necrosis of the mucosa and stenosis of the bronchus just before it disappeared in the tumor mass. This mass filled the dome of the right pleural cavity so that the goiter in the neck practically touched it. But there was definitely normal tissue between the masses and no visible connection between them.

The lymph nodes of the hilum showed white-yellow mottling which we felt was gross evidence of metastasis. The liver showed a single metastatic nodule measuring only 3 cm. in diameter and I hardly think that this tumor was palpable through the skin although the internists are quite diagnostic wizards nowadays. Many smaller

nodules were found in the liver parenchyma and one hepatic vein was thrombosed. The gallbladder contained stones.

The autopsy also could explain the abdominal pain and the positive guaiac test on the stool. There were three acute and superficial ulcers in the duodenum which were covered with fresh blood. In addition the patient had a large adenoma of the left adrenal gland. The kidneys were normal except for some cortical scarring. The uterus had some small fibroid nodules. The ovaries were involuted. The thyroid gland weighed 450 gm. and was nodular in configuration. The individual nodules were soft, yellow and glistening and the gland surrounded and compressed the trachea to some extent. Dissection of the head and brain showed no significant changes.

Microscopic Examination: Sections through the heart valves showed the marked fibrosis with extensive calcification formerly known as Mönckeberg sclerosis of the heart valve. It is now considered a remnant of a previous rheumatic lesion. The heart muscle itself showed mild diffuse fibrosis.

THE LUNGS

Sections through the left lung showed severe chronic bronchitis with obstruction and dilatation of the bronchi. The parenchyma showed fibrosis with atelectasis of the type one sees in chronic pneumonia or in virus pneumonia. There was no evidence of bronchial asthma. No tubercle bacilli or fungi could be demonstrated.

Sections through the right lung revealed similar fibrosis with anthracosis. The tumor in this lung was formed by bizarre-looking large spindle cells with large hyperchromatic nuclei showing a fair number of mitoses. The tumor cells were arranged in loosely aggregated columns and cell nests. There was a small amount of fibrous stroma without significant necrosis. A few giant cells were present. Some cell nests had the distinct appearance of squamous cells with central pearly bodies. All in all the tumor resembled the so-called undifferentiated or anaplastic type of carcinoma arising from bronchial epithelium. The same tumor was also present in the lymph nodes and in the liver.

Sections through the liver also showed focal areas of acute inflammation and ante-mortem thrombi in some of the hepatic veins. Sections through the duodenum showed acute superficial ulcers with evidence of recent hemorrhage. These erosions will produce guaiac-positive stools, give you stomachache and make you vomit. Sections through the thyroid showed a typical colloid goiter. The goiter was quite nodular but nowhere was there any evidence that the thyroid was involved in a neoplastic process. It was definitely of the hypothyroid type.

Thus we concluded that this patient died from a relatively rapidly developing carcinoma of the upper lobe of her right lung which metastasized. It certainly was responsible for the rapid downhill course of the patient. I do not think, however, that it added very much to her respiratory difficulties. The condition in her left lung and her goiter were at least partly responsible for them.

GENERAL DISCUSSION

MEDICAL STUDENT: How do you explain the negative cytological tests?

DR. VON HAAM: The bronchial washings, the sputum and the pleural fluid were reported negative for malignant cells. The pleural fluid may well have been, but the bronchial washings and the sputum should have been positive. That is a mistake for which the pathologist must take the blame. Undifferentiated carcinoma of the lung and tumor cells often look like alveolar cells. It is sometimes impossible to differentiate them.

DR. MORTON: How stenosed was the main right bronchus? It might have been that the cells were not getting out.

DR. VON HAAM: The lumen of the bronchus was big enough so that the cells could have been found.

DR. HARD: How do you explain the fluid in her chest?

DR. VON HAAM: The fluid was cardiac in origin. The patient died in heart failure. There was congestion in her liver and general anasarca. Heart failure is probably the most frequent cause in patients with cancer.

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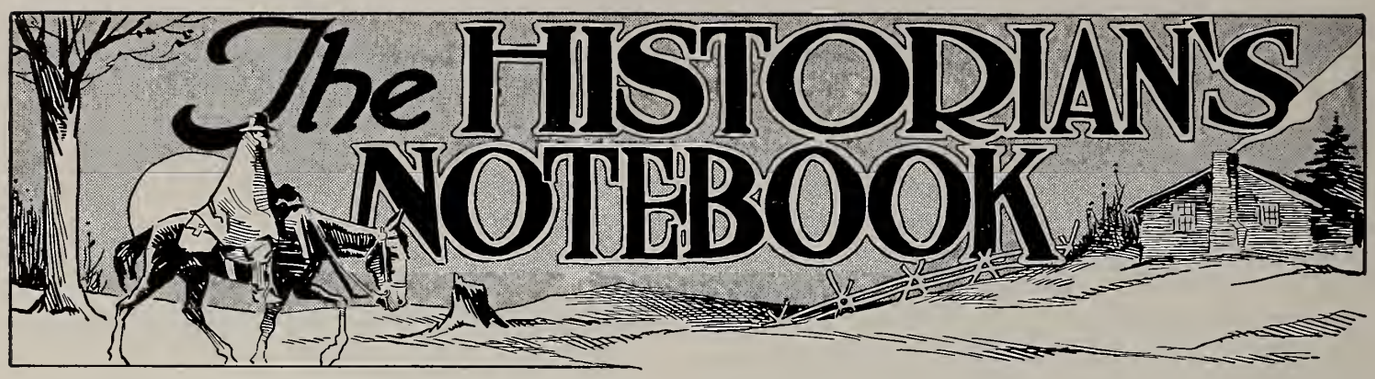
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Strained Meat Formulas for Infants And Children with Food Allergy

Animal meat juice was first used by one of the authors in 1931 for the study and control of possible or definite allergic sensitivity to animal milk. . . .

Strained meat formulas containing approximately the protein, carbohydrate, fat and mineral content of cow's milk have proven valuable in the study of animal milk allergy in infants and children.

Strained meat formulas have been given to over one hundred infants and children with bronchial asthma, eczema and gastrointestinal allergic disease. There were no instances of weight loss or anemia. Clinical improvement was evident in most cases.—Albert Rowe, Jr., M. D., and Albert H. Rowe, M. D., Oakland: *California Medicine*, 81:279, October, 1954.



Censors and Medical Colleges

FREDERICK C. WAITE, Ph. D.

THE word "censor" is derived from a Latin verb meaning to estimate or to investigate. It was applied as a title in Rome in 443 B. C. to two municipal magistrates appointed for five years. These officers were of high dignity with much influence and many duties one of which was to estimate the population of the city, whence comes our modern word "census." This office was continued in Rome for more than 700 years.

The word "censor" has been used in many relations in modern times. Officers called censors in English universities in the eighteenth century conducted examinations and issued licenses. In a few of the United States in the early nineteenth century a board of censors inquired into the actions of public officials. Further discussion is restricted to the use of the word in relation to medical societies and medical colleges.

The method of medical instruction in the American Colonies was by apprenticeship, later called preceptorship. A young man studied with a practicing physician during not less than three calendar years. When the preceptor believed the pupil able to practice medicine independently he issued a certificate of proficiency. When the holder registered this certificate in a court of record he became a legal practitioner of medicine.

ORIGIN OF MEDICAL SOCIETIES

Small groups of physicians met from time to time to discuss medical topics. These groups constituted medical clubs rather than medical societies. Such a club organized in Boston in May 1780 was the source of the founding of Harvard Medical School. Record is found of such clubs in Boston in 1735, and in New York City and in Philadelphia in 1749.

The next step was chartered medical societies. No record has been found of the first chartered medical society. The first state medical society was in New Jersey in 1766 and continued active until 1776. The charters granted by legislatures constituted the medical societies as the legal agents of the state to examine candidates for the practice of medicine. If found proficient they received licenses to practice and were called licensed physicians, which was of a higher grade than legal practitioners.

The first definite law enacted regarding medical practice was by the assembly of the colony of New York in 1760 directing the practice of medicine in New York City but not applied to the rest of the colony. The Massachusetts Medical Society was chartered by an act of the legislature early in the fall of 1781 and the first meeting was held on November 28, 1781. The act directed the society to appoint a committee to determine the proficiency of candidates and issue licenses to practice. Other state medical societies arose and had the same function of creating a board of censors to examine candidates and issue licenses.

The legislature of New York, in 1806, chartered the New York Medical Society and divided the state into three districts in each of which the act directed that a medical society should be organized with a board of censors which should conduct examinations and issue licenses. The number of districts soon increased and county medical societies were organized with the duty of examination by censors and issue of licenses. The county medical societies became the main source of licenses to practice medicine. When a candidate presented a diploma showing that he held the degree of Doctor of Medicine he was

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Submitted August 17, 1954.

excused from examination and a license to practice was issued. This was called "endorsing the diploma." The function of issuing licenses to practice medicine lay entirely in the medical societies until late in the Nineteenth Century when state boards of medical examination and registration were created.

RELATION OF MEDICAL SOCIETIES TO MEDICAL COLLEGES

The Connecticut State Medical Society, in 1812, appointed two delegates to join with the professors of the Yale Medical Institution in examination of candidates for the degree of Doctor of Medicine. The first medical society in Vermont was organized in 1784 and had two censors who examined candidates and issued licenses. Other medical societies followed in Vermont and these joined in 1813 to secure a state charter for the Vermont State Medical Society which in 1821 appointed two delegates to each medical college in the state. Their duties were to visit the medical colleges, inspect the equipment and teaching, join with the medical professors in examining candidates for the medical degree, and make a written report to the parent medical society.

Early medical colleges operated under either an independent charter or under the charter of an affiliated college of arts, however, the medical college was conducted entirely by the medical professors. The public did not always have confidence in medical colleges operated by a group of professors as a private enterprise. Medical faculties welcomed the appointment of subsidiary bodies by higher authority to inspect the institution and join in the examinations of candidates for the medical degree. This procedure enhanced the confidence of the public and especially confidence in medical graduates whose degrees had been issued under joint authority of prominent physicians who were not members of the medical faculties.

These subsidiary groups were known under various designations such as delegates, boards of examiners, boards of visitors, and fellows. However, the prevalent designation was censors. The practice of appointment of censors to medical colleges was begun early in the nineteenth century. The first such appointment has not been determined but the procedure was in operation before 1810. It increased and by the middle of the nineteenth century many medical colleges had censors, although not all of them. Examination of early catalogues shows this procedure to have been common and the names of the censors were printed in the catalogues following the list of the teaching staff.

Appointment as a censor was considered an honor and enhanced the reputation of one who held such an appointment in the region where he practiced. Many men mention that they were censors in the books on biography of American physicians which appeared late in the nineteenth century.

SELECTION OF CENSORS IN MEDICAL COLLEGES

Much care was taken in the choice of censors because their appointments were indefinite and continued until resignation or death. Choice was restricted to physicians who were competent practitioners and had a wide reputation. Those who had been preceptors for a considerable number of private students were preferred because they had experience in teaching medical subjects and in quizzing in the examinations for degrees, which were entirely oral. Most of those who were appointed were either at the time officers of medical societies or had recently been officers. They were chosen from the territory from which the institution drew most of its students and from not far distant localities so that they might easily visit the medical school. Their locations were scattered and in Ohio rarely was more than one censor appointed from any one county.

The decline of the practice of appointing censors in medical colleges was begun in the 1870's when the procedure of preceptorial teaching was declining and more men were attending medical colleges instead of depending entirely upon preceptorial teaching. This left fewer physicians experienced in private teaching of medical subjects. The decline was accelerated in the 1880's when the plan of the graded course of three years appeared. In the graded course written examinations became general and final examinations in some subjects were given at the end of the first and second sessions of the graded course, leaving only a few oral examinations for the degree at the end of the third session. The procedure of censors had almost entirely ended at the end of the nineteenth century although a few sectarian medical colleges continued to have censors until about 1910.

CENSORS IN ONE MEDICAL COLLEGE IN OHIO

The history of censors in one particular medical college may help the reader to get a connected concept of the procedure. The trustees of Western Reserve College in August 1843 appointed a committee of medical examiners. They were called censors by the medical professors. Articles of Establishment of the Medical Department were adopted on March 20, 1844, and provided that the trustees should appoint members of the medical profession as censors, not to exceed five in number, and no more than one from any county.

The trustees appointed the censors until 1858, after which date they were appointed by the medical faculty. The number was five until in 1864 a rival local medical college was founded and appointed nine censors. The medical faculty

of Western Reserve College increased the number to 13, the same as the number of trustees. These two medical colleges were merged in 1881 and the number of censors became 26. Attendance and activity of the censors decreased after adoption of the graded course in 1888. The last censor was appointed in 1890 and the names of censors were not printed in the catalogues after 1897.

Each censor had an equal voice with each medical professor in recommending for the medical degree. The traveling expenses and hotel expenses of censors while in Cleveland were paid, being taken from the graduation fees of the graduates.

A total of 69 men served as censors in the Medical Department of Western Reserve College and University and included many men eminent in Ohio medicine. Five of them were presidents of the state medical society. The term of service varied from one to 42 years with an average of 10 years. Sixty-seven of the number held the degree of Doctor of Medicine.

The practice of censors in medical colleges was an important accessory feature of American medical education throughout most of the nineteenth century. The majority of physicians of the present day are unacquainted with the system which forms a part of the history of American medical education.

Infectious Mononucleosis

Türk in 1907 first made mention of a lymphocytic blood reaction associated with angina and sepsis although Pfeiffer in 1889 had described the clinical entity in children which he called glandular fever. Burns in 1909 initially associated lymphocytosis up to 70 per cent in clinically recognized glandular fever. Deussing was first to report lymphocytosis occurring with glandular fever in children.

In 1923 Downey, for whom is named the atypical lymphocyte that may be one of the hematologic characteristics of infectious mononucleosis, and McKinlay gave a clear cytologic description of the hematologic picture characterizing infectious mononucleosis. Finally, in 1932 the serologic criteria for diagnosis of this disease were set forth by Paul and Bunnell.

Recent reports of cases have been concerned primarily with descriptions of well identified cases of infectious mononucleosis in the adult based upon these established clinical, hematologic and serologic findings. These reports emphasize the extremely protean nature of the disease and enumerate its involvement of nearly every organ of the body.—Fred S. Gachet, M. D., and Walter C. Price, M. D., Lakeland: *J. Florida M. A.*, 41:280, October, 1954.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Emmetropia—This descriptive term designating normal or perfect vision is derived from the Greek words "em" or en, plus "metron," or measure, and "ops," or eye. Hence it literally means an eye which is "in measure".

Electrocardiograph—This name was given to this diagnostic instrument by its inventor Dr. Willem Einthoven, professor of physiology at the University of Leydon, Holland. In 1903 he constructed a delicate string galvonometer with an optical system of projection that was able to graphically record electrical tracings of the heart's action. Einthoven called his tracings electrocardiograms or "telegrams from the heart."

Hand—This most useful part of man's anatomy was probably so named because it is the instrument or organ of holding and seizing. Hand is an Anglo-Saxon word having many related forms such as the Icelandic "hond," the Gothic "hundus," and the German "hand." There is also the Latin term "prehendo," meaning "I lay hold of" or, to seize. These all probably stem from a common root meaning to hold or to seize.

Ectopic—Literally means "out of place" and is derived from the Greek "ec," or out, plus "topos," or place. As for example ectopic pregnancy, a pregnancy in the uterine tube, or used as in ectopica vesicae, denoting an extraversion of the bladder.

Halibut Liver Oil—The fixed oil from the livers of this fish are a rich source of vitamins A and D. The name of this fish which is the largest and most important of the flat fishes, derives its name from "holy" and it was so named because of its extensive use as a food on holy days.

Eclampsia—Derived from the Greek word "eklampsis" meaning a shining forth, this word is composed of the Greek "ek," or out, plus "lampein," to shine. It is an old term and prior to the 18th Century was used for a variety of phenomenon that caused flashes of light to be seen before the eyes, as for example, epilepsy, migraine and syncope. The term then began to be employed for convulsions of all kinds and in about 1760 Sauvages, a French physician, began to differentiate different types of convulsions. He designated the toxic convulsions of pregnancy as "eclapsia parturientum." Later the word eclampsia came to be used by itself for this condition.

Epithelioma—In 1842 the Danish pathologist Hannover suggested that all epithelial tumors be called "epitheliomas." The term is coined from "epithelium" plus the suffix "oma" or tumor.

—Harry Wain, M. D., Mansfield, Ohio.

Tax Roundup for Physicians . . .

Major Changes in Federal Tax Program; How and When To File Reports Under Six Classes of Tax for Which Most Physicians Are Responsible

SHORTLY after the first of the year, physicians will be faced with various tax forms to be filled out and taxes to be paid. Other forms and payments are due at various times throughout the year. This article is published with the purpose of furnishing at least basic information on the following taxes with which most Ohio physicians are confronted:

(1) Federal Income Tax Law, including payroll withholdings on employees' salaries.

(2) Federal Social Security Act including the Old Age and Survivors' Insurance tax and the Federal and State Unemployment Insurance taxes.

(3) Ohio Personal Property Tax Law including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash and accounts receivable.

(4) Ohio Workmen's Compensation Law tax, required of those with three or more employees (optional for those with one or two).

(5) Ohio Sales and Use Tax.

(6) City Payroll Tax, applying to residents of cities which have enacted such a tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

The data and advice presented were obtained from authentic tax publications and from personal interviews with tax officials.

Nevertheless, physicians are advised to obtain supplemental advice and assistance in the preparation of their returns, from competent tax authorities or from staff members of the office of the District Directors of Internal Revenue or other appropriate agency. A tax expert may point the way to substantial savings as well as steer the taxpayer around embarrassing errors.

FEDERAL INCOME TAX

Most taxpayers will find two-fold relief in paying their 1954 Federal Income taxes. In the first place, a decrease in tax liability became effective January 1, 1954, when certain provisions of the Revenue Act of 1951 expired; and, secondly, the Revenue Code of 1954 recently enacted by Congress provides tax relief for many taxpayers.

Most of the provisions of the 1954 Code are applicable to transactions and computations affecting income for the calendar year 1954. There are, however, many special effective dates scattered throughout the new code.

Effort has been made to incorporate into this article major changes in the law which have broad application. Changes which apply to specific cases are too numerous to list in detail.

INCOME-SPLITTING

The income-splitting provision which has been in effect for several years, has not been changed in principle under the new law. A husband and wife in many cases may effect substantial reductions by making a joint return.

Under certain conditions a taxpayer whose husband or wife has died during either of his two preceding taxable years may claim income-splitting.

HEAD OF A HOUSEHOLD

A "head of a household" may claim about one-half of the tax benefit which is given to a married couple on a joint return because of income-splitting. The head of a household is defined as an unmarried individual, other than a nonresident alien, who maintains as his home a household constituting the principal place of abode and has as a member or members of such household one or more dependents as defined in the provisions. The new law expands this

definition to include a dependent parent living elsewhere.

FORMS AND PAYMENTS

Every person under 65 years old whose gross income for the year was $600 or more, and every person 65 years old or older whose gross income was $1,200 or more, must file certain income tax returns with the District Director of Internal Revenue for his district not later than April 15, 1955. Payment to cover tax liability should accompany the form.

There are three types of returns, Form 1040A, Short-Form 1040 and Long-Form 1040.

Form 1040A may be used only if the income was less than $5,000 and consisted entirely of wages reported on Withholding Statements, or such wages and not more than $100 total of other wages, interest and dividends (excluding $50 of dividends). When this form is used the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund.

Short-Form 1040 is used if the income is less than $5,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Long-Form 1040 must be used if the income was $5,000 or more, or if the taxpayer wishes to claim nonbusiness deductions that amount to more than 10 per cent of income.

DECLARATION OF ESTIMATED TAX

The provisions for filing declarations of estimated income taxes are principally for those persons, a substantial part of whose income is not subject to withholdings.

When filling a final return for 1954 income, most physicians will have to file an estimate of 1955 income. However, if most of a physician's income is from wages subject to withholdings, in some instances he will not have to file an estimate. For example, a single person must file an estimated return if his gross income from wages subject to withholdings can be expected to exceed $5,000. A married couple (including head of a household or a surviving spouse) must file if the estimated gross income subject to withholdings is over $10,000.

Under the new law, the time for filing declarations of estimated tax and income tax returns has been moved up one month to April 15. The three other dates for filing estimated returns remain the same—June 15, September 15 and January 15. There is an exception on the January 15 date, but it is not effective until 1956.

If the estimated tax paid is 70 per cent or more of the actual tax liability, no penalty is assessed.

PHYSICIANS IN PRIVATE PRACTICE

Most physicians in private practice therefore must comply with the following procedures:

1. File a complete income tax return for the preceding year, not later than April 15.
2. Pay the difference, if any, between the income tax paid quarterly during the year based on estimated income, and the amount of the tax computed on his final return. If he has overpaid, the excess will be refunded or credited against future payments.
3. File a declaration of estimated tax liability for the current year by April 15, and pay either the full amount or one-fourth of it. If he elects to pay quarterly, the remaining final dates for payment are June 15, September 15 and January 15.

For physicians who find it difficult to estimate their income in advance, it is suggested that they use the previous year's income as a basis and later file an amended declaration if the situation changes considerably.

ADJUSTED GROSS INCOME

Individuals who are employed and receive a salary have little difficulty in arriving at the amount of their adjusted gross income. The total salary received plus amounts received from interest, dividends, rent, or from other sources, would in such cases constitute the gross adjusted income.

Persons with retirement income would do well to study the new law in regard to many changes on such income.

Dividends to the extent of $50 are excluded from gross income. Husband and wife both get the exclusion if both have dividend income. There are several other changes in the new law in regard to income from interest and dividends.

Interns, residents and other persons employed by institutions may be materially affected by this provision: Meals and lodging are excluded from gross income if (1) meals are furnished on the premises of the employer, and (2) lodging on the premises is required as a condition of employment.

The physician in private practice has more difficulty in arriving at his adjusted gross income than the person on salary. From the amount of his cash receipts—if he reports income on the basis of cash received and disbursements, or on the amount of total charges if he uses accrual method of reporting his income—he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections:

DEDUCTIBLE BUSINESS EXPENSES

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he cannot claim deduction for office rent. However, he is entitled to

claim depreciation on that portion of the property occupied as an office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. On the assumption that the useful life of an automobile is four years, the government allows 25 per cent of the cost price for depreciation each year. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the number of miles the car is driven for professional purposes. If a physician possesses two cars, each of which is used partly in professional business the deductible depreciation on each car should be computed on the basis of the number of miles each car is driven for professional purposes.

Declining-balance method may be used on new automobile purchased after December 31, 1953, if the useful life is three years or more.

The physician should seek the advice of a tax expert as to whether or not application of the "declining-balance method" (explained in the instructions which accompany the tax forms) would be advantageous to him.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted.

Expenses incurred by a physician in attending postgraduate courses relevant to the field in which he is practicing may be deducted. However, it is likely that deduction would not be allowed for expenses in attending courses which are designed to prepare the physician for a new area of practice—for example, to prepare a general practitioner for a specialty or a specialist for another specialized field.

Traveling Expenses—Traveling expenses necessarily incurred by a physician on professional calls and in attending medical conventions for a professional purpose are deductible from gross income.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicine, Supplies, Etc. — Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Equipment, Furniture, Library, Etc.—Cost of surgical instruments and laboratory appliances of more or less permanent value may not be deducted but a percentage of the purchase price may be deducted annually under a depreciation account. The same rule applies to office furniture and books purchased for the physician's office library. If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

Depreciation—Physicians will particularly benefit from provisions of the new law in regard to depreciation. In general, this provision permits the taxpayer to charge off a larger proportion of the cost of equipment during its early life.

Liberalized depreciation privilege is restricted to assets with a useful life of three years or more, and to property (1) construction of which is completed after December 31, 1953, but only with respect to that portion of the basis of such property attributable to construction, reconstruction or erection after December 31, 1953, or (2) acquired after December 31, 1953, if the original use commences with the taxpayer and commences after that date.

Uniforms—The Internal Revenue Department permits deduction of the cost of medical uniforms as a business expense. In general, any apparel used in practice but not suitable for general wear, may be included under this heading.

General Office Expenses — The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept ac-

cording to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i. e., all fees, either cash or account are included in income reported for tax purposes) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—State and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as nonbusiness deductions only.

Fees and expenses paid for "securing the right to practice" are not deductible, such as the fee paid to secure a license from the State Medical Board. Other license fees which the physician is required to pay, including narcotic tax and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business, is to be taken as a nonbusiness deduction only. The tax paid on telephone bills if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills is not deductible. Federal taxes on amusements, club dues, furs and luxuries are also not deductible for Federal income tax purposes.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Sales Tax Payments—The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are deductible as business expenses. Other amounts expended for sales tax are nonbusiness deductions and not to be taken as business expenses.

Ohio and Federal Gasoline Taxes—There is a five cents per gallon Ohio tax on gasoline, and a two cents per gallon Federal tax. These amounts are deductible. However, if a physician has already included overall cost of gasoline as part of his business expenses, the tax is not again deductible. The Ohio 5 cents tax paid on gasoline not used in business is deductible as a nonbusiness deduction. The Federal tax is deductible only as a business expense.

Interest—Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as nonbusiness deductions. Interest paid to carry tax free securities may not be deducted. The interest deduction may not exceed the portion of the total carrying charges attributable to the taxable year.

Carrying charges on installment purchases up to 6 per cent of unpaid balances are deductible where the taxpayer has carrying charge separately stated in installment sales contract.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible.

Under the new law the cost of contesting tax liabilities is deductible.

EXEMPTIONS AND ALLOWANCES

An exemption of $600 may be claimed by the taxpayer for himself. He may also claim an exemption of $600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a dependent, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than $600 for the year. A child may earn $600 or more and still qualify as a dependent if

he is under 19 or a full-time student, or taking on-the-farm training, provided the taxpayer contributes more than half of his expenses.

An additional personal exemption of $600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

NONBUSINESS DEDUCTIONS

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, **providing that there is not a duplication of deductions under the two categories.**

Contributions, Gifts, Etc.—The individual taxpayer may now deduct contributions up to 30 per cent of adjusted gross income, if the last 10 per cent is given to a church, an association of churches, an educational institution or a hospital. The ceiling remains at 20 per cent for contributions to other charitable organizations, no substantial part of the activities of which are carrying on propaganda or otherwise attempting to influence legislation.

Medical and Dental Expenses—There have been substantial changes in this category. The taxpayer may deduct medical and dental expenses which exceed 3 per cent of the adjusted gross income. However, in figuring these expenses, the amount paid for medicine and drugs may be taken into account only to the extent it exceeds 1 per cent of the adjusted gross income.

The deduction may not exceed $2,500 multiplied by the number of exemptions other than the exemptions for age and blindness. In addition there are maximum limitations as follows: (a) $5,000 if the taxpayer is single and not a head of household or a qualifying surviving widow or widower; (b) $5,000 if the taxpayer is married but files a separate return; or (c) $10,000 if the taxpayer files a joint return, or is a head of household or a qualifying surviving widow or widower.

If the taxpayer or his wife is 65 or over, the maximum limitations are the same as in the foregoing paragraph. However, amounts deductible for medical and dental expenses are not restricted to the excess over 3 per cent of adjusted gross income. In effect the 3 per cent rule may be disregarded. But the amounts spent for medicine and drugs are still limited to the excess of 1 per cent of income, and amounts spent for dependents' medical expenses are deductible only to the extent they exceed 3 per cent of adjusted gross income.

Medical expenses paid by an estate within one year after death are considered paid by the decedent.

The term "medical care" is broadly defined to include "amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance)."

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and amount. It should be noted that this will furnish the Internal Revenue Department with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

Interest—The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

Taxes—Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, auto license fees, state gasoline taxes.

Casualty Losses and Thefts—The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, if not claimed as a business deduction and not covered by insurance.

OPTIONAL STANDARD DEDUCTION

The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes, and other nonbusiness deductions is 10 per cent of the adjusted gross income, but not in excess of $1,000, or $500 in the case of a married person filing a separate return.

DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Director of Internal Revenue, Federal Building, Water and Gay Sts., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Galia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Director of Internal Revenue, 626 Huron Rd., Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe,

Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Director of Internal Revenue, Post Office Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Director of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

INCOME TAX WITHHOLDINGS

Every employer who pays wages to one or more employees, where an employer-employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Handbook* after having the employee fill out Form W-4 to determine the number of exemptions he claims.

The handbook is supplied by the District Office of the Director of Internal Revenue. The employer should check to see whether the employee has become eligible for additional allowances, or otherwise comes under a new withholding bracket in 1955.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941, quarterly during the month immediately following the quarter for which deductions are made. (Social Security taxes are reported on this same form.)

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

DEPOSIT OF WITHHOLDINGS

An employer who withholds as much as $100 per month for the purposes of income tax liability and F. I. C. A. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depositary receipt, Form 450, is then eligible for use.

REPORT OF FUNDS PAID

As in previous years, payments in excess of $600 made during the year for interest, rents or commissions, not subject to withholdings and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15 of the following year to the Director of Internal Revenue, Processing Division, Kansas City, Mo.

SOCIAL SECURITY TAXES

The Federal Social Security Act embodies laws pertaining to Old Age and Survivors' Insurance and Unemployment Insurance. Because the procedures for paying these taxes are different, they are discussed here under separate headings.

Increased benefits for Social Security under the new law became effective in September 1954. Increase in the amount of salary on which deductions are made is effective January 1, 1955. Provisions in the new law for coverage of persons not formerly covered become effective January 1, 1955.

A person 65 years old or older who is receiving Social Security benefits may now earn up to $1,200 a year without losing his benefit. For any excess earnings over $1,200 he may lose one month's benefits for each $80 or fraction thereof. A person 72 or older may earn any amount and continue to draw benefits.

Not covered for social security purposes are services performed by an individual in the employ of his son, daughter, or spouse, and services performed by a child under 21 in the employ of his father or mother.

Under provisions for coverage of self-employed workers, physicians are specifically excluded, as are self-employed dentists, lawyers and certain other professional people.

Domestic workers in private homes who receive wages of at least $50 in a quarter are covered. Under the new law, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns $50 or more in a quarter (approximately $3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who is paid at least $100 in cash wages by a single employer in a quarter must be covered.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

OLD AGE AND SURVIVORS' INSURANCE TAX

The Old Age and Survivors' Insurance Tax is payable by every employer who employs one or more persons in his office or home.

The employer deducts 2 per cent of the em-

ployee's wages at each pay period and contributes a like amount himself. The amount of salary for each employee on whom deduction is made during the year has been increased to $4,200, effective January 1, 1955.

The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed prior to April 30, for the months of January, February and March of that year, in the office of the District Director of Internal Revenue, and quarterly thereafter, payable during the month after the quarter ends.

The employer who hires household help only should file on Form 942, which is in the form of an envelope for convenient mailing. If the employer has already enrolled with the Internal Revenue office for payment of Social Security taxes for office employees, he may add his domestic workers to the same Form 941 on which he reports other employees.

Farm workers must be reported on Form 941. They may be reported on the same form with office employees.

UNEMPLOYMENT TAX

Physicians or other employers who have three or more employees, including other physicians, nurses, receptionists, technicians, office workers, etc., are subject to the Ohio Unemployment Compensation Tax. Those who have had eight or more for a substantial part of the year are liable also for the Federal Unemployment Insurance Tax.

OHIO UNEMPLOYMENT COMPENSATION TAX

In general, employment of three or more persons in any one day including part-time workers renders the employer liable for this tax. A physician who is in doubt as to his liability, should request clarification from the Bureau of Unemployment Compensation, 427 Cleveland Ave., Columbus 16.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax rate is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This shows how the rate for the employer for that year was calculated. This rate starts at 2.7 per cent and may be reduced to as low as one-tenth of one per cent. Only the first $3,000 paid by any employer to any one individual within a calendar year is taxable.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the Bureau will request separation and wage information from the employer. It is imperative that this form requesting separation information be returned to the Bureau within seven days of its receipt.

FEDERAL UNEMPLOYMENT TAX

The Federal Unemployment Insurance Tax applies only to employers who have had eight or more persons on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year. The gross tax is three per cent on all individual wages up to $3,000 and is paid exclusively by the employer—the employee making no contribution. A credit not to exceed 90 per cent of this tax is allowed on all payrolls which were reported to the state unemployment compensation agency (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state unemployment tax in full, the Federal tax is reduced to three-tenths of one per cent.

OHIO WORKMEN'S COMPENSATION

The purpose of the Industrial Commission of Ohio is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing three or more employees regularly in the same business is required to furnish the Industrial Commission with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of less than three employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by September 1 for the first half of the year, and by March 1 for the second half of the year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The main office of the Industrial Commission is in Columbus. Branch offices are maintained in Akron, Canton, Cincinnati, Cleveland, Dayton, Hamilton, Lima, Mansfield, Martins Ferry, Portsmouth, Toledo, Youngstown and Zanesville.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and

March 31 annually. One-half of the amount of the tax is paid when the return is filed, and the other half is due September 20.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies, etc. Such tangible property should be listed at its book value. A depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced 5 per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

Form 937, obtained from the Ohio Department of Taxation must be filed with the Personal Property Tax return to obtain a lesser value than 30 per cent.

Returns should be made in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

Accounts receivable are to be listed in accordance with Section 5711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

As defined in Section 5701.07 R. C., credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75 per cent, 50 per cent, 25 per cent, 10 per cent, etc., of its full face value, or of "no value" in case that is considered the "actual value" of this account. The total of these estimates is the total to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

Some physicians misunderstand the provision requiring the listing of accounts receivable for taxation. Some think that physicians are the only ones who have to do so and that the law is discriminatory. That is not true.

Every person who possesses intangible assets, *such as accounts receivable*, or any business or professional man who does business on a credit basis and keeps books, must return his accounts receivable for taxation.

Such person must keep in mind that he can estimate depreciation on his accounts receivable and that he can use *accounts payable* as an offset against accounts receivable, paying the tax on the difference.

Obviously, the percentage discount used by a physician in depreciating the value of his accounts receivable will depend to a large extent on the doctor's collection experience and on the economic status of the majority of his patients. In other words, the physician who has difficulty in collecting bills or whose practice serves a large number of persons in the low-income brackets or who are poor credit risks, should use a higher depreciation formula than the physician who does not have these factors to contend with.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by next April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

Section 5739.01, Revised Code, contains this provision: "Physicians and dentists are consumers of all tangible personal property purchased by them in connection with the practice of medicine or dentistry. They shall not be required by any provision of Sections 5739.01 to 5739.31, inclusive, and 5741.01 to 5741.22, inclusive, of the Revised Code, to collect sales or use tax on property

transferred by them to patients in connection with the rendition of professional services provided that if physicians and dentists are engaged in selling to consumers tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, the tax shall apply to such sales."

CITY PAYROLL TAX

Several cities in Ohio have enacted laws imposing income tax on wage earners and making the employer responsible for deducting the tax from wages paid employees. For example, Columbus has a law which requires the employer to deduct one-half of one per cent of the employee's wages and make returns to the city auditor quarterly. A physician who moves into a new location should inquire as to what tax laws may be in force locally.

Special Tours Will Be Coordinated With 1955 Medical Meetings

Several tours have been arranged by the Kirkland Travel agency in coordination with important medical organization meetings in 1955 and one has been arranged by the United Air Lines.

A special tour train will leave Chicago on March 23 for the Scientific Assembly of the American Academy of General Practice in Los Angeles, March 27-30. Several air or combination air-steamer tours are planned also for the Invitational Scientific Congress of the A. A. G. P. in Honolulu, April 5.

One tour is coordinated for the 20th anniversary meeting of the International Surgical Congress in Geneva and the A. M. A. Meeting in Atlantic City. The tour leaves New York April 30 and returns to Atlantic City June 6.

Another tour leaves after the A. M. A. Annual Session in Atlantic City, June 11, and returns to New York July 22. Tour includes London at the time of the 12th congress of the International Association of Psychotechnology. An extended tour may be arranged to Scandinavian countries for the meeting of the International Society of Surgery, July 24-31.

A tour will depart from New York August 30 and will include on its itinerary the World Medical Association meeting in Vienna, September 20-26.

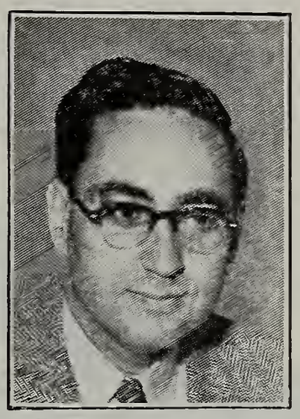
Additional information on the above tours may be obtained by writing: Lee Kirkland Travel, 1231 Baltimore Ave., Kansas City 5, Mo.

The United Air Lines has arranged an air tour of European countries following the A. M. A. Meeting in Atlantic City. The tour leaves New York on June 12 and returns July 10. Additional information may be obtained by writing: A. M. A. Post-Convention Tour, c/o United Air Lines, 5959 South Cicero Ave., Chicago 38, Ill.

Dr. Dwork Named Director of the Ohio Department of Health

Governor Frank J. Lausche recently appointed Dr. Ralph E. Dwork director of the Ohio Department of Health for a five year term beginning November 8, 1954, and ending November 7, 1959.

Dr. Dwork was tentatively designated for the post shortly before Dr. John D. Porterfield relinquished the directorship to assume his new duties as director of the Department of Mental Hygiene and Correction. Dr. Dwork was named assistant director and assumed the post as acting director on last July 1.



R. E. DWORK, M. D.

Dr. Dwork, in addition to being a physician holds a master's degree in public health from the Columbia University School of Public Health. He studied medicine at the University of Edinburgh and Anderson College of Medicine, Glasgow, Scotland, where he received his L. R. C. P. S. degree in 1946. His internship was in Syndenham Hospital, New York City. He also took residency work in chronic diseases at National Jewish Hospital, Denver.

He came to Ohio in 1950 when he accepted an appointment as chief of the Ohio Department of Health's Division of Chronic Diseases.

Advisory Council on Reserve Medical Affairs Established for Army

Organization of a council of five general officers from the Army Medical Corps Reserve to advise The Surgeon General on matters related to the medical reserve matters has been announced by the Department of the Army.

Maj. Gen. George E. Armstrong, The Surgeon General of the Army, welcomed the officers invited to form the council at the initial session held Monday, October 25 at his office. He declared their advice would be sought on special reserve items having far reaching impact on the health professions of the nation as well as on those problems concerning the general activities of the Army's medical reserve.

The council members, all of whom were present at this first meeting, include: Brig. Gen. Perrin H. Long, College of Medicine, State University of New York; Brig. Gen. Alexander Marble, Joslin Clinic, Boston, Mass.; Brig. Gen. I. S. Ravdin, professor of surgery, University of Pennsylvania School of Medicine, Philadelphia; Brig. Gen. Harold G. Scheie, assistant professor of ophthalmology, University of Pennsylvania Graduate School, Philadelphia; and Brig. Gen. Frank E. Wilson, director of the Washington Office of the American Medical Association.



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Hydrochloride
Tetracycline HCl Lederle

ACHROMYCIN, new broad-spectrum antibiotic, has set an unusual record for rapid acceptance by physicians throughout the country. Within a few months of its introduction, ACHROMYCIN is being widely used in private practice, hospitals and clinics. A number of successful clinical tests have now been completed and are being reported.

ACHROMYCIN has true broad-spectrum activity, effective against Gram-positive and Gram-negative organisms, as well as virus-like and mixed infections.

ACHROMYCIN has notable stability, provides prompt diffusion in body tissues and fluids.

ACHROMYCIN has the advantage of minimal side reactions.

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

Lederle

*REG. U.S. PAT. OFF.

Application

For Space in the Scientific and Educational Exhibit

1955 Annual Meeting • Ohio State Medical Association

Netherland Plaza Hotel Cincinnati, Ohio April 19-22, 1955

Fill Out and Mail to:

BRUCE G. MacMILLAN, M. D., *Chairman*
Committee on Scientific and Educational Exhibits
Christian R. Holmes Hospital
Eden and Bethesda Avenues,
Cincinnati 19, Ohio

DEADLINE FOR APPLICATIONS . . . FEB. 15, 1955

1. Title of Exhibit: _____
2. Description or nature of exhibit (attach 200-word description to this blank).
3. Will radiologic viewing boxes be needed? If so, state number and size:
   Number of boxes needed _____ Size required _____
   (Please indicate if you plan to furnish own view box.)
4. Will you require shelf space? If so, how much? _____
5. How much floor space will you require? _____
6. How much back wall space will you require? _____
7. How much side wall space will you require? _____
8. Other material or equipment required: _____
9. Name of exhibitor: _____
   _____ (Street) _____ (City)
10. Name of institution cooperating in exhibit (if desired):

_____

_____

_____

_____

Booths will have a back wall and two side walls. The side walls of all booths will be four feet wide. The back wall of most of the booths will be 8 feet long; a few will be somewhat smaller. If an exhibitor needs more space, or a space with special dimensions, he should explain in detail in writing to the Exhibit Chairman. In most instances, the standard booth should be sufficient.

The height of the back and side walls will be eight feet. However, because of the standard shelf in all booths, only five and one-half feet of wall space will be suitable for exhibit material.

Why Attend The Annual Meeting?

President Prugh Points Out Why It Is Important for Members To Take in The 1955 Gathering in Cincinnati, April 19, 20, 21, and 22

NOT long ago a fellow practitioner of mine asked me this question: "Why should I attend the O. S. M. A. Annual Meeting?" He had seen some information in *The Journal* regarding plans for the 1955 meeting in Cincinnati, April 19-22. I told him why I thought he should attend. I've given some additional thought to the question. Here are some reasons which apply to any Ohio physician.

You owe it to yourself. You'll get a real lift in gathering with your fellow physicians for a common purpose. You'll learn many things which you can apply in your daily practice. You'll realize the real meaning of the word "colleague." You'll be making a contribution to something which means unity in the medical profession of Ohio.

You owe it to your colleagues. Progress which has been made in medical science has coincided with the growth and activity of organized medicine. There can be no progress without teamwork. There can be no teamwork without a team. There can be no team without members. You are a member of the team which sponsors and supports the Annual Meeting which offers many things of value for all of the 8,000 plus physicians of Ohio.

You owe it to your patients. You don't hand your patient a pamphlet and tell him to read up on his ailment, diagnose it and treat it. By the same token, doctors cannot keep up with new things in medicine, even though they are professionally trained, by just reading medical articles. Physicians were among the first to realize the importance of getting together and discussing common problems. I'm sure all of us must admit that usually we learn much more in hearing discussions and participating in question-and-answer sessions than by wading through essays, important as they may be.

You owe it to your community. Most citizens of every community look to their physicians as advisers and counselors on medical and health matters. They expect their doctors to be up-to-the-minute on medical and health questions. Much of our social progress has resulted from progress in scientific medicine and public health. I'm sure our patients like to know that we are constantly taking refresher work so that we can give them and the entire community the best of modern medical and health services.

There may be other valid reasons as to why you should plan now to take in the 1955 Annual Meeting in Cincinnati, April 19-22. Nevertheless, the four reasons given should be sufficient to convince you that the Cincinnati meeting should be a "must" on your 1955 calendar. Get your reservation for hotel space in immediately. A reservation blank is appearing monthly in *The Journal.* The program will appear in the March issue. You'll be receiving some direct mail on this from the Columbus Office. Plan now to attend, as I am of the opinion the Cincinnati meeting will be one of the best in the Association's history.

MERRILL D. PRUGH, M. D.,
President.



Going to Cinc'y . . . ? . . .

for the 1955 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION? The dates are Tuesday-Friday, April 19-22, but it's an excellent idea to make HOTEL RESERVATIONS well in advance. This list of leading downtown Cincinnati hotels is given for your convenience. Clip the coupon at the bottom of this page and mail it to the hotel of your choice with your specifications.

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BEDS
NETHERLAND PLAZA HOTEL	$5.50-12.00	$10.00-12.00	$10.50-15.50
ALMS HOTEL			$ 8.00-10.00
BROADWAY HOTEL	$3.50	$ 5.50- 6.50	$ 7.50-10.00
CINCINNATIAN HOTEL	$3.00- 5.00	$ 4.00- 7.00	$ 5.00- 8.00
METROPOLE HOTEL	$5.00- 8.00	$ 7.50- 9.00	$ 8.50-11.00
SHERATON-GIBSON HOTEL	$5.35-12.35	$ 8.35-12.35	$ 9.35-15.85
SINTON HOTEL	$4.35-11.35	$ 6.85-11.35	$ 9.85-14.85
TERRACE PLAZA HOTEL	$9.50-15.00		$12.50-18.00
VERNON MANOR	$4.00	$ 5.00- 6.00	$ 6.00- 9.00

Persons who desire suites or other additional accommodations are advised to specify their needs to the hotel of choice.
(All rates subject to change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Cincinnati, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 19, 20, 21, 22, 1955, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price .....

☐ Twin Bed Room with Bath ☐ Additional Accommodations (Specify)

Arriving April ..... at ..... A.M. ..... P. M.

PLEASE VERIFY MY RESERVATION

Name .....

Address .....

.....

More Physicians To Be Reclassified . . .

State Selective Service Issues New Order Applying to Priority No. 3 Registrants Born, 1915-1932; Large Call-Up Expected Next March

OHIO Selective Service Boards have been directed to make a reclassification of doctors of medicine with no previous active military duty (Priority No. 3) whose year of birth was 1932 through 1915 in order to set up a pool from which a large induction quota for the armed services can be met in March, 1955. Physicians born since 1932, who are in Priority No. 3, have already been reclassified.

This order is covered in Administrative Memorandum No. 32 issued on November 16 by State Selective Director C. W. Goble and based on a directive from National Selective Service Headquarters.

Under the order, local boards will be expected to secure recommendations as to the availability in each individual case from the appropriate advisory committee, of all those Priority No. 3 physicians whose date of birth falls in the period 1915 to 1932, inclusive, according to Dr. Drew L. Davies, chairman of the State Medical Advisory Committee to Selective Service.

Clearance also will be requested in Priority No. 1 and Priority No. 2 physicians who are not on active duty.

There is no information available at present as to what the Ohio quota will be in meeting the large call-up of physicians expected for next March which is referred to in detail in Administrative Memorandum No. 32 issued by Director Goble:

NOVEMBER 16, 1954.
ADMINISTRATIVE MEMORANDUM
No. 32 (1954)

MANPOWER DIVISION
SUBJECT: VOLUNTEER ADVISORY COMMITTEES—SPECIAL REGISTRANTS AND NEW REPORT OF AVAILABILITY

1. Information has been received from National Headquarters, Selective Service System, that the Department of Defense has requested the Selective Service System to deliver for induction 1,275 Doctors of Medicine and 459 Doctors of Dentistry during the month of March 1955.

2. We have been requested to furnish a report, tabulated as of November 30, 1954, indicating the number of physicians and dentists in this state in I-A and I-A-O examined and acceptable, as follows:

1. Number of Priority I Physicians—all ages.
2. Number of Priority II Physicians—all ages.
3. Number of Priority III Physicians by each year of birth for the years 1932 through 1915.
4. Number of Priority I Dentists—all ages.
5. Number of Priority II Dentists—all ages.
6. Number of Priority III Dentists by each year of birth for the years 1932 through 1910.

3. You will note that these calls require consideration in Priority III of older physicians and dentists. It is, therefore, directed that the classifications of registrants in II-A, III-A and unclassified be reopened and considered anew in accordance with my authority and contained in Paragraph 1625.2. Of particular importance will be the reopening and consideration anew in Priority III of Physicians for the years of birth 1932 through 1915 and dentists from the years of birth 1932 through 1910.

4. In each instance, the Local Board should immediately direct the Clerk to prepare Mimeo Forms 1113 and forward them to the appropriate committee identified in Administrative Memorandum No. 32 (July 1, 1954).

5. Kindly advise by return mail the number of special registrants who will require the armed forces physical examination so that we might make arrangements to accomplish such examinations.

6. It is requested that the report, as of November 30, 1954, be completed no later than that date and forwarded to this Headquarters inasmuch as they must be tabulated and submitted to National Headquarters no later than December 3, 1954.

7. Should there be any misunderstanding concerning this Memorandum, kindly advise at once.

C. W. GOBLE,
The State Director,
Selective Service.

Second District Society Elects Officers

The Second District Medical Society at its recent meeting in Dayton elected Dr. T. L. Light, Dayton, president. He is the president-elect of the Montgomery County Medical Society.

Other officers elected are: Dr. Martin Cook, Springfield, vice-president; Dr. Frank Anzinger, Springfield, secretary, and Dr. William Hanning, Dayton, treasurer.

Industrial Commission . . .

Over $6 Million Paid Out by State Agency for Medical Services to Workers During Year; Reach All-Time High in Number of Claims

THE Industrial Commission of Ohio during 1953 paid out $6,093,626.69 for medical services to injured Ohio workers, according to information furnished by the Actuarial Section of the Commission. That amount included a relatively small sum for dental services.

Medical payments for 1953 were somewhat under 1952, principally because 1952 payments included carry overs from some of the preceding years.

Other expenditures during the year, exclusive of compensation payments included: $6,883,628.48 for hospital care and nursing; $286,209.41 for funeral expenses; and $476,170.04 for miscellaneous costs. With disbursements for medical expenses added, the total is $13,739,634.62.

These amounts include payments covering treatment of injured private and public employees, as well as similar costs for occupational disease claims.

Comparative figures for 1952 were as follows: $6,888,165 for medical service; $6,055,942 for hospital care and nursing; $269,043 for funeral expenses, and $218,055 for miscellaneous costs; a total of $11,172,716.

The number of claims filed during 1953 was 347,182 or 3.8 per cent more than in 1952. It was the greatest number filed in the 42 year history of the Ohio Workmen's Compensation Fund. Previously, 1943 and 1952 were the peak years.

"Medical-only" claims, involving payment for physicians' services, but with no compensation to the claimant for loss of time, numbered 243,661 for 1953, or 70 per cent of all claims filed. The average amount paid out for "medical-only" claims increased from $14.71 in 1952 to $15.41 in 1953.

Table 1 is a financial statement of Ohio Insurance Fund.

Table 2 gives 1953 awards that have been made for active claims according to the year of injury and having injury dates which in some instances reach back to the beginning of the fund. (1912)

TABLE 1

OHIO STATE INSURANCE FUND
(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION
As of December 31, 1953

ASSETS

	Private	Public	P.W.R.E.	Safety & Hygiene	Total
Cash	$ 4,216,136.81	$ 181,079.12	$ 27,073.40	$ 22,897.76	$ 4,447,187.09
Bonds	150,148,651.04	6,209,333.89	823,687.08	1,219,690.49	158,401,362.50
Premiums Due	31,882,204.33	3,621,737.40	5,076.85	----------	35,509,018.58
Adm. Cost Assmt. Due	976,996.76	82,786.02	64.76	----------	1,059,847.54
Accrued Interest	789,088.90	32,632.44	4,328.79	6,409.94	832,460.07
Total Assets	$188,013,077.84	$10,127,568.87	$860,230.88	$1,248,998.19	$200,249,875.78

LIABILITIES

Reserve for Medical & Compensation Claims	$152,133,750.00	$10,126,810.00	$ 82,579.00	$ ----------	$162,343,139.00
Reserve for Allocated Surplus Adjustment	----------	707.68	----------	----------	707.68
Balance of Allocation for Rehabilitation Center	136,389.79	----------	----------	----------	136,389.79
Advance Premium Deposits	25,175,591.57	----------	----------	----------	25,175,591.57
Fund	----------	----------	----------	1,248,998.19	1,248,998.19
Reserve for Contingencies and Surplus	10,567,346.48	51.19	777,651.88	----------	11,345,059.55
Total Liabilities	$188,013,077.84	$10,127,568.87	$860,230.88	$1,248,998.19	$200,249,875.78

TABLE 2—PRIVATE FUND

1953 Medical, Hospital, Etc., Awards Distributed to Year of Injury Occurrence
(Accident and Occupational Disease Combined)

Year of Accident or Disease	Medical Hospital, Etc.	1953 Per Cent	1952 Per Cent
1953	$ 6,000,149	46	47
1952	3,777,706	29	36
1951	979,671	8	5
1950	589,901	5	2
1949	313,533	2	2
1948	283,180	2	3
1947	181,042	1	1
1946	136,914	1	1
1945	108,100	1	1
1944	90,949	1	1
1912 - 1943	474,883	4	1
	$12,936,028	100	100

Rehabilitation Legislation . . .

Analysis of Provisions of New Federal Law and What Has To Be Done In Ohio To Take Advantage of Them; Matching of Funds Required

PUBLIC Law 565, enacted by the Congress this year, is designed to broaden and expand programs of vocational rehabilitation for the handicapped. Public Law 482, also enacted this year and commonly known as a measure to expand the provisions of the Hill-Burton Hospital Construction Program, is in some respects a companion law to Public Law 565.

What effect these two Federal laws will have on the situation in Ohio will depend to a large extent on (1) actions taken by the Ohio General Assembly when it meets in 1955 and (2) the amount of financial support given by the state and local communities, inasmuch as the Federal programs carry matching-of-funds provisions.

Here are some facts regarding the new legislation and how Ohio can take advantage of it during the fiscal year 1954-55.

BASE ALLOTMENT

(1) The **base allotment** of federal funds as provided under Section 2 of Public Law 565 for the Bureau of Vocational Rehabilitation is $357,780.00. This will require an additional expenditure of state funds to the amount of $170,000.00. The base allotment of federal funds for Vocational Rehabilitation Services for the Blind is $133,185.00. This will require an additional expenditure of state funds to the amount of $46,000.00.

SUPPLEMENTAL FUNDS

(2) **Additional funds** provided under Section 2 by the supplemental appropriations of $1,500,000.00 are available to Ohio to the amount of $48,016.00 which must be met by an expenditure of state funds amounting to $40,985.00. This allotment is available to both the Bureau of Vocational Rehabilitation and Vocational Rehabilitation Services for the Blind for expansion of basic services. Specific amounts are to be determined by mutual agreement by the two agencies.

NEW ACTIVITIES

(3) In addition to the above two categories, a third allotment of Federal funds is available to Ohio for **"Extension and Improvement"** under Section 3 of the Act. This allotment amounts to $76,962.00 for Ohio and requires a state expenditure of $25,654.00. Definite project plans for such expenditures must have Federal approval and must involve rehabilitation activities not now embraced by the present program. Since this amount is available to both the Bureau of Vocational Rehabilitation and Vocational Rehabilitation Services for the Blind, the specific amounts must be determined by mutual agreement.

FACILITIES

(4) Under the **1954 amendments to the Hospital Survey and Construction Act** (Public Law 482) approximately $126,000.00 per year of Federal funds will be made available to Ohio for the construction of rehabilitation facilities. (Additional Federal funds will also be available under this same Act for the construction of chronic disease hospitals, nursing homes and treatment or diagnostic centers.)

The Act provides that each state shall survey its facilities and based upon determined needs make the plan for construction of the above four categories of facilities. A Federal allocation of approximately $80,000.00 will be available to Ohio for surveying the need for these facilities. Allocations to the state for survey and planning, as well as for construction must be matched dollar for dollar by state, municipal, or private funds or any combination of these.

In Ohio this Act will be administered by the U. S. Public Health Service through the State Department of Health. The Act requires the state hospital construction agency (Ohio Department of Health) to secure advice from non-government groups or state agencies concerned with rehabilitation. Projects for rehabilitation facilities, unlike the other categories, require the approval of the Secretary of the Department of Health, Education and Welfare in addition to that of the Surgeon-General.

SPECIAL PROJECTS

(5) An appropriation of $1,000,000 was voted for grants for **special projects.** Grants may be made to States and public and other nonprofit organizations and agencies for paying part of the cost of projects which hold promise of making a substantial contribution to the solution of problems in the vocational rehabilitation field common to all or a number of States or problems for which the Federal Government has a special responsibility. Such projects are designed to—

(a) Encourage new concepts and techniques to raise the whole level of competency in providing rehabilitation services.

(b) Provide Federal participation in demonstration projects to develop advanced methods in group action in communities, industries, etc., to achieve rehabilitation of disabled persons.

(c) Undertake a program of research which

would provide the new knowledge needed to overcome some of the technical and other obstacles which now interfere with successful rehabilitation in many instances.

(d) Plan and carry out a program of training of personnel in the several professional fields required to provide rehabilitation services as a prerequisite to the expansion of vocational rehabilitation.

(e) Provide Federal grants to the States under conditions which will encourage the States to undertake a more rapid expansion of vocational rehabilitation services.

In carrying out this program of special projects, the new law provides for a National Advisory Council on Vocational Rehabilitation with responsibility for reviewing all applications for such projects and recommending action to be taken. The appropriation bill requires that the grantee, or the grantee and the State, must spend no less than $1 of their own funds to match each $2 in Federal funds for any project.

TRAINING PROGRAMS

The new law also provides that among the purposes for which special grants might be made is that of paying part of the cost of **training and traineeships.** In addition, the Act provides that the Secretary of Health, Education, and Welfare shall provide short-term training and instruction in technical matters relating to vocational rehabilitation services. The Office of Vocational Rehabilitation has emphasized that in order to attain the goals of the expanded rehabilitation program, more and better rehabilitation personnel must be produced and there must be undertaken research in rehabilitation methods and techniques. In addition to qualified physicians trained in the principles and practices of rehabilitation and physical medicine, there are acute shortages of rehabilitation counselors, physical therapists, occupational therapists, rehabilitation facility administrators, personal adjustment and orientation specialists for the blind, selective placement specialists, and others. To make a start toward the training of the additional rehabilitation personnel required, Congress has appropriated $900,000.

Two Veteran Physicians in Mental Hospital Work Will Retire

Two key physicians in the State mental hospital program have announced their retirements effective December 31.

Dr. Arthur G. Hyde will retire after serving as superintendent of the Massillon State Hospital for 36 years. He will continue a private practice in Massillon.

Dr. Chester C. Kirk will retire after serving as superintendent of the Orient State Institute since 1927. He will be succeeded by Dr. Robert L. Frazier, assistant superintendent.

New Members of O. S. M. A.

The following are the names of the new members of the Ohio State Medical Association since October 8, 1954. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY
Joseph C. Avellone, Lakewood
Matthew R. Biscotti, Parma
Rudolph Bognar, Cleveland
Frank H. Critchfield, Jr., Cleveland
Robert E. Eckel, Cleveland
James W. Ensign, Cleveland
Fridolph E. Erlandson, Jr. Cleveland
Gordon N. Farner, Cleveland
George H. Feil, Cleveland
Amasa B. Ford, Cleveland
Harold W. Ford, Cleveland
Betty J. Fratianne, Cleveland
Paul O. Funk, Cleveland
Joseph L. Galione, Cleveland
Charles K. Guttas, Cleveland
Charles M. Greenwald, Cleveland
John W. Harrison, Cleveland
William F. Hughes, Jr., Cleveland
John P. Jasko, Avon Lake
Hugh B. Kelly, Cleveland
Louis L. Keppler, Jr., Cleveland
Jefferson D. Kernodle, Cleveland
Drue King, Jr., Cleveland
Justin Krent, Cleveland
Rudolph G. H. Leuchtenberger, Cleveland
Albert J. Mendel, Cleveland
Thomas W. Moir, Cleveland
Georgia Reynolds, Cleveland
George B. Richardson, Cleveland
William K. Runyeon, Cleveland
Joseph Schu'tz, Cleveland
Morton A. Shaw, Cleveland
John Storer, Cleveland
William C. Strittmatter, Cleveland
Morris W. Stroud III, Cleveland
Robert D. Weekley, Cleveland

CLINTON COUNTY
Mary Ranz Boyd, Wilmington

GUERNSEY COUNTY
Howard D. Miller, Cambridge

HAMILTON COUNTY
Laurence L. Essig, Cincinnati
Paul S. Hough, Cincinnati
Francis H. Hutchinson, Cincinnati
David M. Kerman, Montgomery
Mary Kathyrn Lavrich, Cincinnati
Roy J. Lewis, Cincinnati

HAMILTON COUNTY (Continued)
John A. MacLeod, Cincinnati
William R. Puttmann, Cincinnati
Kenneth W. Rahe, Cincinnati
Arthur B. Snowhite, Cincinnati

LICKING COUNTY
Paul W. McCracken, Newark
Hector C. McKnew, Jr., Newark
Irving A. Nickerson, Granville
Benjamin Zolo, Newark

LORAIN COUNTY
DeWitt E. Harrison, Elyria
Jack P. Mercer, Lorain

LUCAS COUNTY
Robert A. Gwinner, Toledo
Frank P. LoFiego, Toledo
Lt. (j. g.) Richard C. Oudenhoven, Great Lakes, Illinois.
Landon Palmer, Toledo
John B. Rank, Toledo
Rolland Scherbarth, Toledo

MARION COUNTY
James A. Schuler, Marion

MONTGOMERY COUNTY
James L. Chestnut III, Dayton
Austin H. Hammond, Dayton
N. F. Stambaugh, Dayton
Robert L. Swartzel, Dayton

ROSS COUNTY
Paul F. MacCarter, Chillicothe
David McKell, Chillicothe

SCIOTO COUNTY
Louis M. Schoettle, Portsmouth

STARK COUNTY
William B. Epps, Massillon
Harold A. Leader, Jr., Canton
Jerry I. Newman, Canton
Donald G. Pocock, Massillon
Franklin D. Swan, Massillon

SUMMIT COUNTY
Paul Eugene Frye, Akron

TRUMBULL COUNTY
Charles S. Dalton, Coshocton
Walton I. Droba, Farmdale
Rupert A. Havill, Warren
Richard W. Juvancic, Niles
Edward W. Mencher, Cortland
John V. Wilber, Warren

Sight Conservation in Schools . . .

A Guide To Help Standardize Procedures Throughout the State Is Approved by Professional Advisory Committee on Sight Conservation

SUGGESTIONS which may be used as guides by schools, health departments and others who are engaged in sight conservation programs or who contemplate the initiation of such activities have been issued by the Ohio Department of Health to all local health commissioners and superintendents of schools.

The suggested policies for vision conservation programs were published by the Ohio Department of Health following approval by the Professional Advisory Committee on Sight Conservation which was established by former Director of Health Dr. John D. Porterfield in the fall of 1951. The Advisory Committee is composed of representatives in the fields of ophthalmology, optometry, health, education, welfare, and the Health Commissioners' Conference.

PHYSICIANS ON COMMITTEE

Physicians on the Advisory Committee include: Drs. Claude S. Perry, Robert Magnuson, Margot D. Hartmann and John D. Porterfield, all of Columbus, and Dr. Margaret O'Neal, Zanesville.

The reason for and objectives of the Committee resulted from the fact that sight conservation activities in Ohio have grown "without the benefit of a uniform state policy to guide local agencies," as was stated by Dr. Porterfield in 1951. The work of the Committee involves guidance for the establishment of "a more intensive and scientifically reliable program," he said.

According to Director of Health Dr. Ralph E. Dwork, the issuance of policies will be followed by pertinent forms and literature for general distribution, and later a manual of procedure. Consultant services for local vision screening programs are available from the Ohio Department of Health or its district offices, he said.

Following are the policies as published:

METHODS AND DEVICES OF VISION SCREENING

The Committee approved the use of a device (or devices) for vision screening in the schools incorporating the use of the Snellen Chart and capable of yielding a score utilizing the twenty foot distance. The test should not be administered at less than ten feet. It was decided that the following screening tests meet the above standards: The Snellen wall chart, the lighted Snellen Chart (Portable Visual Acuity Chart—Good Lite Company), and the projector type test (American Optical Company — Projectoscope; Bausch and Lomb-Acuity Projector, etc.).

STANDARDS

The following standards for referral to an eye specialist were agreed upon by the Committee:

a. Nurse or teacher observations of children with functional disorders.

b. Pass-fail criteria (utilizing the Snellen type test):

1. Refer all children below the third grade level who fail to read the 20/40 line.
2. Refer all children at the third grade level and above who fail to read the 20/30 line. One letter failure is allowed per line.

c. The following basic vision screening program was approved by the Committee:

1. Test all first grade pupils and all other students transferred from other school districts.
2. Test all students referred from other grades by either teachers or nurses.
3. Re-check annually each child who wears glasses.
4. Test third or fourth grade pupils depending upon the time when the print in textbooks is reduced.
5. Test sixth grade pupils (or when the print changes again).
6. Test ninth grade students. (There is often a final change in print.)

d. The Committee approved the appointment of a small sub-committee composed of representatives from the Departments of Welfare, Education and Health and a representative from the Health Officers' Conference to develop various necessary forms for use in the screening program. This should insure uniformity of records in the various departments and agencies interested in a vision program.

e. The following definition of "eye specialists" to whom children who fail screening tests may be referred for professional services, were accepted by the Committee: (These definitions are identical with those provided by the National Society for the Prevention of Blindness with one minor exception):

"Ophthalmologist" and "oculist" are synonomous and designate a physician who has specialized in the treatment of eye diseases and optical defects. Such a person is licensed to practice medicine and surgery in all its forms including the prescription of glasses.

"Optometrist" indicates a nonmedical prac-

titioner licensed to treat optical and muscle defects of the eyes without the use of drugs or surgery. He may prescribe glasses and give muscle exercises. Status may be designated by the initials O. D. (for Doctor of Optometry) or the word "optometrist" after the name.

COMMUNITY PROGRAMS

a. The Committee favors the establishment of advisory committees on the local level composed of eye specialists, health and education personnel and representatives from other interested agencies or service clubs. Such committee could be very helpful to health and education authorities in developing policies on referral of children failing vision tests, and on referral of cases in need of financial assistance to appropriate local agencies.

b. The Committee agreed that teachers should be encouraged to administer screening tests to their pupils. Since the teacher is in close association with her charges, she would be in the best position to note not only symptoms of eye difficulties but also other gross physical and psychological symptoms.

The teachers should be included in program planning from the beginning so they would know the part they are to take. If it is not feasible for teachers to do the screening, they should be responsible for preparing their respective classes for the screening test, for referring pupils with symptoms of eye problems and for offering basic instruction in care of the eyes.

As an alternative, if the teacher is unable to administer the vision test, it is suggested that the local board of education pay for the services of a substitute teacher, ex-teacher or ex-nurse to do the screening.

Volunteer lay persons from P. T. A.'s, Women's Clubs or other service organizations could be utilized as "screeners."

Local public health and school nurses should be quite familiar with the techniques of screening testing. Their prime responsibility should be to recheck children who have failed the screening test to assure the accuracy of the basic screening.

Consultants from the Ohio Department of Health will be available for training nurses, teachers and/or lay persons in the techniques of vision screening.

VISION CLINICS AND FOLLOW-UP

In certain rural areas where there are no eye specialists and where vision screening programs have begun it may be advisable to conduct diagnostic eye clinics to facilitate the examination of children who may need medical care or corrective lenses. Whether there is an actual need for itinerant clinics will be determined after the program has been in operation for some time. If such a need can be demonstrated, the Ohio State Medical Association would have to endorse the establishment of clinics. The State Health Department could arrange and pay for the services of eye specialists.

In order to provide a more complete clinical service, a pediatrician and other specialists (such as a psychologist, speech therapist, an audiologist, a dentist) may form a team to evaluate any additional health needs these children may have.

The follow-up of recommendations made by either the local or the visiting specialist should become the responsibility of local public health departments. Assistance for special cases may be requested from the Division of Special Education, State Department of Education and/or the Division of Social Administration, Medical Services for the Blind, State Department or Welfare. Reports of the status of follow-up for each child referred to a specialist should be made periodically to the Division of Child Hygiene, Ohio Department of Health. Consultants from the Ohio Department of Health will assist local health departments in this regard.

PROCEDURAL MANUAL

A procedural manual is to be developed outlining the vision conservation program. This will include the steps in the development of a program, inter-agency relationships, responsibilities, definition of approved standards, criteria to be recommended, etc. In brief, this manual will be designed to describe all the details of a vision program.

Cincinnati Physician Heads National Committee on Air Pollution

A committee of the American Public Health Association, newly organized under the chairmanship of Dr. John J. Phair, Cincinnati, will study possible nationwide control procedures in the field of air pollution. The committee will recommend to the parent association policies in regard to research and study in the field as well as control.

Dr. Phair is professor of preventive medicine in the University of Cincinnati College of Medicine. He hopes to integrate with the national plan the local program of research in air pollution already under way in his department.

Scientific Editorial Conference

The third conference on Scientific Editorial Problems will be held December 29-30 on the campus of the University of California, at Berkeley. The conference is a permanent feature of the annual meetings of the American Association for the Advancement of Science. All persons interested in scientific writing, editing or publishing are invited to attend.

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (Intended residence and medical school of graduation also are given):

June 17, 1954—Herbert C. Bradley, Jr., Germantown, University of Louisville; George T. Harding, IV, Worthington, College of Medical Evangelists; Richard J. Ireton, Columbus, Harvard Medical School; Morris Kramer, Sandusky, University of Zurich, Switzerland; Forest F. Radcliff, Jr., Germantown, University of Louisville; Thaddeus Stabholz, Fremont, University of Vermont; Joseph Tauber, University of Prague, Czechoslovakia; Ernest A. Turpin, Jr., Columbus, Albany Medical College; Karl F. Welte, Cleveland, University of Berlin.

August 31, 1954—Goffredo S. Accetta, Cincinnati, Yale Univ.; Robert L. Bierbower, Univ. of Nebraska; Philip E. Binzel, Jr., Cincinnati, St. Louis Univ.; Lewis Booker, Cleveland, Univ. of Virginia; Kendall O. Burns, Cleveland, Indiana University;

Joseph E. Campbell, Columbus, Harvard Med. School; Dorothy B. Chamberlin, Bowling Green, Albany Medical College; Thomas P. Coleman, Akron, Univ. of Minnesota; Lee J. Cordrey, Cleveland, Temple Univ.; Leonard V. Crowley, Columbus, Univ. of Vermont; Robert J. Dane, Columbus, State Univ. of Iowa;

John W. Edwards, Lancaster, Temple Univ.; Valeria J. Enright, Columbus, Georgetown Univ.; Donald S. Freiburger, Cleveland, Northwestern Univ.; Alvin E. French, Dayton, Albany Medical College; John R. Gehring, Bellaire, Harvard Medical School; Joseph F. Gibney, Columbus, New York Univ.; Henry Goldhirsch, Youngstown, Univ. of Lausanne, Switzerland; Helen R. Gottschalk, Cincinnati, Washington Univ.; Horace Graffini, Cincinnati, Univ. of Rome (Italy); Charles M. Greenwald, Cleveland, Columbia University;

Daniel J. Hanson, Toledo, Univ. of Minnesota; James F. Hoffman, Lyndhurst, Univ. of Buffalo; Thomas A. Huffman, Ravenna, Univ. of Rochester; Ralph M. Jones, Toledo, Univ. of Tennessee; Patricia M. Kamsler, Columbus, Temple Univ.; Robert D. Kummer, Cleveland, Univ. of Buffalo;

Leo Levieff, Cleveland, Univ. of Lausanne, Switzerland; George H. Lohrman, Columbus, Marquette Univ.; Hector C. McKnew, Jr., Newark, Univ. of Maryland; John W. Metcalf, Jr., Toronto, Univ. of Maryland; William B. Millberg, Ashtabula, Jefferson Med. Col.; Hugh K. Moir, Univ. of Toronto; Joseph H. Nodurft, Univ. of Illinois; Skender Nuredini, Toledo, Univ. of Bologna, Italy;

Eric M. Peterson, Columbus, Temple Univ.; Daniel W. Platt, Steubenville, Chicago Medical School; Franklin H. Plotkin, Cleveland, State Univ. of New York; Leonard S. Pritchard, Columbiana, Univ. of Pittsburgh;

Hamilton W. Ratledge, Cincinnati, Univ. of Michigan; Harold E. Reed, Kent, Temple Univ.; Walter H. Riester, Bellaire, Columbia Univ.; Julian H. Robinson, Columbus, Meharry Med. Col.; Marvin C. Rulin, Youngstown, Chicago Medical School;

Dana R. Schmidt, Columbus, Duke Univ.; Ndoc Shllaku, Toledo, Univ. of Bologna, Italy; Julian Sileckyj, Lorain, Univ. of Munich, Germany; Carl N. Simpkins, Jr., Columbus, Univ. of Georgia; Gordon L. Smith, Columbus, Univ. of Illinois; Carl E. Solomonson, Niles, George Washington Univ.; John H. Spencer, Dayton, State Univ. of Iowa; William C. Strittmatter, Cleveland, Univ. of Michigan; Franklin D. Swan, Massillon, Loyola Univ.;

John R. Thompson, Univ. of Michigan; Saunders J. Thompson, Youngstown, Howard Univ.; Francis S. Walker, Cleveland, St. Louis Univ.; George M. Wyatt, Cincinnati, Washington Univ.; Benjamin Zolo, Newark, New York University.

October 5, 1954—Samuel Biern, Jr., Johns Hopkins University; William R. Biddlestone, Cleveland, University of Tennessee; Willa L. Caldwell, Columbus, Howard University; Russell J. Catalano, University of Buffalo; Morriss Chamurich, Toledo, University of Edinburgh, Scotland;

Nikolaus Dejczakiwskyj, Lorain, University of Munich, Germany; Joseph Dudas, University of Innsbruck, Austria; Joel C. Fink, Cleveland, University of Maryland; Sylvan Frieman, Dayton, University of Maryland; Terrance D. Furness, Cleveland, Hahnemann Medical College;

Edward D. Hudgens, Jr., North Madison, Tulane University; Andrew Kallos, Portsmouth, University of Paris; Saul R. Kelson, Toledo, Cornell University; Adrian G. Krudy, Cleveland, University of Wurzburg, Germany; Edwin H. Lawson, Bowling Green, University of Illinois;

Walter A. Massie, Mansfield, Temple University; Robert R. Nairn, New London, University of Pennsylvania; James E. Nousek, Jr., Cleveland, St. Louis University; Michael A. Pierce, Columbus, Albany Medical College; Edmond R. Plunkett, Barberton, George Washington University; Richard C. Proplesch, Toledo, University of Buffalo;

Conrad O. Ranger, Columbus, University of Montreal; William P. Robison, Columbus, University of Georgia; Jaime C. Smith e Incas, Columbus, Howard University; Tibor P. Winkler, Cleveland, University of Munich, Germany; Robert E. Welty, Lima, Indiana University.

Hospital Admissions . . .

Cincinnati Institution Goes Far in Alleviating Troublesome Problem of Admitting Patients on Basis Most Equitable to All Persons Concerned

IN the face of hospital bed shortages in many communities, one of the most troublesome problems confronting physicians, as well as hospital officials, is endeavoring to set up a plan of admitting patients on a basis most equitable to all concerned.

One of the best plans in effect in Ohio appears to be that worked out by the Jewish Hospital, Cincinnati. Its details and results were discussed by Dr. David H. Ross, superintendent of Jewish Hospital, in a communication published in a recent issue of *The Journal of the American Medical Association.*

The Jewish Hospital plan may offer some excellent ideas which can be adopted by other Ohio hospitals confronted with this problem. The communication by Dr. Ross describing it reads as follows:

PRIORITIES FOR HOSPITAL ADMISSIONS

The hospital I serve has been able to successfully solve a problem that has been perplexing many hospital administrators, medical staffs, and communities. It is the challenge of admitting patients on the most equitable basis.

The situation confronting most hospital administrators is the demand for hospitalization in the face of bed shortages. Because of these demands, most administrators have found themselves in the harassing position of meeting pressures brought to bear on themselves, on their board of trustees, and on the hospital's medical staff by community members who seek to influence their own or their friends' early hospital admission.

If the community member making such an imperative request is the wife of a member of the board of trustees, the brother of an officer of the medical staff, a friend who has donated $5,000 to the hospital in its building campaign, or a person of no prominence who is equally ill as all the rest, who should be given admission preference? Each feels that his request is one that demands immediate attention and action, and, yet, what administrator can properly and equitably make such a decision?

MEDICAL NEED

In solving this problem in the face of popular demands for service that have frequently resulted in a daily occupancy of 100 per cent or over and in reducing "pressurizing attempts" to almost a zero point, our hospital's administration and medical staff have utilized a system that affords equity on a common level of consistent application. It is the most just and humane system—one in which the determining criteria are considerations of medical needs.

By using this system, the acutely or emergently ill are provided with immediate hospitalization. Those, the urgently ill, who medically can afford a short wait are given next consideration. Those whose nonurgent illness would not be affected by a longer wait receive attentions after provisions have been made for emergently and urgently ill patients. The declaration of the category into which each patient being admitted is included is made by the person most qualified to do so—the patient's own physician.

THE EVER-PRESENT HUMAN ELEMENT

Although, by and large, a high level of cooperation has been consistently maintained by medical staff members in making this category declaration, community and personal pressures made on these physicians, and the human factors involved, sometimes result in deviations in the so-called honor system.

Therefore, our self-governing and self-policing medical staff—assisting the hospital in protecting the rights of patients and the criteria of admission on the basis of medical need—has set up a screening committee to evaluate the declarations of illness category. This committee consists of members of the various medical and surgical specialties, appointed by the president of the medical staff, who examine the various category declarations given by the physicians.

PROCEDURE

The procedure by which our screening committee has met the problem of admission on a medical need basis is as follows: A physician, calling for an accommodation in what he feels is an emergency situation, is given the name of the physician-member of the screening committee on duty for the day, if the need is a medical one; if the situation involves need for surgery, he is given the name of the surgeon-member of the screening commitee on duty. He then immediately contacts the proper screening committee member, explains the emergent situation, and generally receives approval for inclusion of his patient on the emergency list for immediate priority admission.

After the patient's admission, the attending physician fills in an "emergency" form, which then becomes a permanent part of the chart and is subject to later review. If it is the considered opinion of the consulted member of the screening

committee that the situation does not warrant emergency admission, and the need for such decision has become less and less frequent, the request for admission on the urgent list is then made by the attending physician.

CHRONOLOGICAL ORDER

This procedure involves the filling out of a special "urgent" request form in the admitting office prior to the patient's admission. This form is reviewed by the member of the screening committee in his daily routine scrutiny of all such requests. On receipt of approval, the patient's name is then placed on the urgent list, in chronological order, and the patient is admitted as quickly as possible from that list. Should the screening committee feel that the situation is not urgent, it indicates referral to the nonurgent (or elective) list.

NONURGENT ADMISSIONS

All requests for admission for medical service on a nonurgent basis are made by the completion by the attending physician of a "nonurgent" request form in the admitting office, and these forms are subsequently reviewed by the member of the screening committee on duty in his daily routine check of all urgent and nonurgent applications. Should the committee member feel that there is some doubt as to the necessity of hospitalization, the attending physician is asked for clarification and additional information. The request is then reevaluated by the committee member on duty for the day, and, if necessary, it is referred to the chairman and the whole committee for consideration. Admissions from the medical nonurgent list are made only in chronological order.

For surgical nonurgent (or elective) admissions, the attending physician or surgeon need fill in no form. Paralleling operating room time and bed accommodations are given in accordance with the patient's turn on the nonurgent surgical list.

The medical staff has set up an additional audit in the reviews of the medical records committee and its two subunits; the survey committee reviews the charts of all "emergency" admissions and the records committee reviews all urgent and nonurgent medical and surgical charts, except those of routine tonsillectomy, obstetric, and newborn patients. The very occasional impropriety is referred to the executive board of the medical staff for consideration of action against the offending physician or surgeon.

Through judicious and consistent application of the policy of admission on the basis of medical need, the Jewish Hospital Association has been able to impartially and fairly discharge its obligations to those it serves, without members of the board of trustees, the administration, or the medical staff being placed in the distressing position of making a decision in favor of one ill person at the possible medical expense of another.

Do You Know?...

Dr. Henry Luidens, for several years chief of professional services at the Veterans Administration Hospital, Chillicothe, has been named manager of the Coatesville, Pa., V. A. hospital.

* * *

Dr. William F. Ashe in October assumed his new duties as professor and chairman of the Department of Preventive Medicine, Ohio State University, upon his return from a Point Four mission to India. He flew to India in September to act as consultant in thermal environmental health in India's industrial plants. He will return to India periodically to continue the study and help formulate recommendations.

* * *

Dr. Louis J. Wise, Cincinnati, has been elected president of the east-central division of the American Association of Psychiatric Clinics for Children. Dr. Wise is associate director of the children's division of the Community Chest's Central Clinic and associate director of the Child Guidance Home, the center supported jointly by Jewish Hospital, Community Center, State Division of Mental Hygiene and the University of Cincinnati Psychiatry Department.

* * *

Dr. Charles A. Bowers, Cleveland, was elected president of the Ohio Society for Crippled Children at its 35th annual meeting in Columbus.

* * *

When the new building is opened in January, Peoples Hospital, of Akron, will become known as the Akron General Hospital. In announcing the proposed change, the Board of Trustees said: ". . . During the past 40 years we have outgrown our name just as we have outgrown our original building . . ."

* * *

Dr. Vinton E. Siler, associate professor of surgery, University of Cincinnati College of Medicine, discussed "Important Clinical Factors of Acute Pancreatitis," at the Pan-Pacific Surgical Association meeting in Honolulu in October. Dr. Siler, with the assistance of Dr. John H. Wulsin, has made an extensive study of pancreatitis at Cincinnati General Hospital.

* * *

For the first time in 25 years a psychiatrist has been named to head the Juvenile Diagnostic Center in Columbus. He is Dr. Roger M. Gove, whom Dr. John D. Porterfield, director of the Department of Mental Hygiene and Correction, appointed in mid-October. Dr. Gove has been in the Division of Mental Hygiene for a number of years and recently has been assistant mental hygiene commissioner. The new appointment transfers him to the Division of Juvenile Research, another branch of the Department of Mental Hygiene and Correction.

Red Cross Will Supply Globulin in 1955 For Use in Measles and Hepatitis

The Ohio Department of Health will continue to distribute gamma globulin in 1955 for use in measles and infectious hepatitis through local health departments, in keeping with a program that is now being formulated, according to Dr. Martin D. Keller, of the Department's Division of Communicable Diseases, who said that the supply would come from the American Red Cross beginning January 1.

The announcement was made following a recent statement by the Office of Defense Mobilization that it would discontinue its program of controlled distribution of gamma globulin after December 31. (Refer to November issue of *The Journal*, page 1096.)

Ohio physicians may be assured that high priority will be given to the supply for use against infectious hepatitis. For use in the modification or prevention of meales, the supply will be available for use on children under 3 years old, for older patients with debilitating diseases, pregnant women and other patients whose conditions warrant its use.

The American Red Cross announced from its Washington office that upon termination of the O. D. M. Control, the Red Cross will resume gamma globulin distribution for use against measles and infectious hepatitis "through state health departments on percentage basis to be developed later."

In accordance with the established American Red Cross policy, no gamma globulin it distributes will be sold. Since that policy was set up in April 1944, almost 19 million cc. of gamma globulin have been made available without charge for the product. Of this amount, more than 8 million cc. were distributed through state health departments from April 1944 up to the O. D. M. control date of January 1, 1953, the Red Cross reported.

To comply with Red Cross policy, physicians who administer Red Cross g. g., secured through health departments, may charge their usual fee for professional services but should not include a charge for the product. The same rule applies to hospitals.

As far as use in poliomyelitis is concerned, it appears now that there will be no supply of g. g. available for distribution by the health departments after December 31, Dr. Keller said. Any gamma globulin used for polio patients would have to be obtained through commercial channels.

Brooklyn (Cuyahoga County)—Dr. Samuel J. Webster was honored by the Brooklyn Kiwanis Club for 50 years of service to his community.

Cambridge—Dr. George F. Swan has been named to a three-year term on the Board of Trustees of Muskingum College.

How About a Contribution To O. S. U. Medical Student Lounge?

Here's a chance for the medical and nursing alumni of Ohio State University (and other interested Ohio physicians and nurses) to make a financial contribution to a project designed to make life more pleasant for the boys (and their wives, if any) and girls attending the College of Medicine and School of Nursing and those taking postgraduate training at the University Hospitals.

A Medical Center Students' Lounge is being set up in Hamilton Hall. You've guessed it—there hasn't been any. One's badly needed.

Furniture is needed. The Medical College Council and the Nursing Student Faculty Government have started the furniture fund from their treasuries. A lot more is needed. The University is providing the space and is standing the cost of lighting fixtures, flooring, painting, etc.

The plan is to get minimum basic furniture now and as soon as possible to get more small lounge chairs, tables, card tables, reading and floor lamps. At some later date the hope is to develop a small room next to the lounge as a serving kitchen for teas, meetings, and banquets.

The several wives' clubs of the Medical Center Students, Medical Student's Wives, Intern and Residents' Wives, Nursing Alumni, Student Nursing Council will use the lounge as a relaxing spot during the day and evenings as a meeting room.

One furniture firm has planned the room in sturdy and attractive Early American Maple. It offers two chairs, a captains' chair or a Windsor type chair, with a metal name plate bearing the name of the donor for the cost of $30.00 each. The donor may specify his choice in a letter with his contribution.

Contributions should be sent to the Development Fund, Health Center Student's Recreational Fund, Project No. 5495, O. S. U., Columbus, Ohio. Any contributions sent to the Development Fund are income tax deductable. This project is under the direction of the Dean of the Medical College.

Inquiries may be sent to the President of the Medical College Council, Hamilton Hall, O. S. U., Columbus, Ohio, or thru the Development Fund. Mention should be made of the project number and name so that this project will be sure to get the donation. Other larger pieces of furniture included in the plan for the room are needed and any unspecified contributions will be used as partial payment on these items.

Alliance—Dr. George L. King, president of the Board of Trustees of Mount Union College, was awarded the honorary degree of Doctor of Laws by that institution.

Chagrin Falls—Dr. Paul H. George spoke at a meeting of preschool parents on the subject, "What To Do Before the Doctor Comes."

Washington Roundup . . .

News From Nation's Capital of Interest to Physicians; Reports of Developments in Medical and Health Fields; Activities of Agencies

Army Surgeon General George E. Armstrong has appointed five Brigadier Generals of the Medical Corps Reserve to serve as a consultant group on Reserve matters: Drs. Perrin H. Long, Alexander Marble, I. S. Ravdin, Harold G. Scheie, and Frank E. Wilson. The last is director of the Washington office of the American Medical Association.

* * *

Advertising claims for "SSS Tonic" are to be toned down, under agreement between Federal Trade Commission and the product's Atlanta manufacturer.

* * *

In the new Congress, Rep. John E. Fogarty, (D., R. I.) will resume chairmanship of the House appropriations subcommittee, which handles annual funds bill of the Department of Health, Education and Welfare. This includes public health, vocational rehabilitation, social security, food and drug, etc. He held the same position in the 82nd Congress.

* * *

Four of the five doctors of medicine in the House of Representatives were re-elected to serve in the 84th Congress. Rep. Will Neal (R., W. Va.) lost to the man whom he beat for the seat two years ago. The four physicians who won house seats again are Drs. Ivor D. Fenton, (R. Pa.); Thomas E. Morgan (D., Pa.); A. L. Miller (R., Neb.); and Walter H. Judd (R., Minn.).

* * *

Rear Admiral Ross T. McIntire, personal physician to the late President Franklin Roosevelt and one-time director of the American Red Cross, running for Congress on the Democratic ticket from San Diego, was beaten by the incumbent, Rep. Bob Wilson (R., Cal.), a dentist.

* * *

The Senate Labor and Welfare Committee will be presided over in the 84th Congress by Senator Lister Hill of Alabama, replacing William Purtell of Connecticut. Senator James E. Murray, chairman of the committee in the Democratic 82nd Congress would be entitled to the post, but has decided to take the chairmanship of another committee.

* * *

U. S. farmers have been warned by the Federal Civil Defense Administration that they are vulnerable to biological warfare attack by enemy agents or airplanes carrying disease-laden mists and destructive chemicals. In a new handbook, *What the Farmer Should Know about Biological Warfare,* farmers are informed how to detect and fight such attacks against their crops or animals.

* * *

The House Interstate and Foreign Commerce Committee, which handles most medical legislation in the House, will be under the chairmanship of J. Percy Priest, of Tennessee, replacing Charles Wolverton, of New Jersey.

* * *

At the XIV Pan American Sanitary Conference, meeting in Santiago, Chile, the Pan American Sanitary Bureau approved a program aimed at eradicating malaria from the Western Hemisphere.

* * *

The Korean GI Bill sent 4,926 veterans to medical school and another 1,705 to pre-medical training during the first two years of its existence, a recent report shows.

Sixth District, After Successful Session, Sets 1955 Meeting

With the purpose of avoiding conflicts with other programs in the area, Sixth District physicians set Wednesday, October 26, 1955, for their next annual fall postgraduate day. The place is the Packard Auditorium, at Warren.

This year's session held on October 27 in Akron, probably set an all-time record for attendance at a district program. There were 638 persons in attendance.

An excellent all-day program was held, climaxed by a banquet in the evening.

Obstetrics and Gynecology Board Examinations Scheduled

The next scheduled examination of the American Board of Obstetrics and Gynecology (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada, and military centers outside the continental United States, on Friday, February 4, 1955.

Case Abstracts numbering 20 are to be sent by the candidate to the secretary as soon as possible after receiving notification of eligibility to the Part I written examination. The secretary is Dr. Robert L. Faulkner, 2105 Adelbert Rd., Cleveland 6, Ohio.

In Our Opinion: Comments on Current Economics and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

LESSONS LEARNED FROM "THE DOCTOR WAS A FAKE"

Did you read the amazing story, "The Doctor Was a Fake," in the November 13 issue of *The Saturday Evening Post?* If not, do so. Then you'll wonder how on earth Harold Kenneth Rain, who never went to medical school and never had a license to practice, could possibly have got away with his impersonations for seven years in so many communities, including one Ohio town.

Part of the answer will be found in the final paragraph of the article which is as follows:

"The shortage of medical help, the fear of giving offense, a wish to avoid trouble, a low index of suspicion, and neglect to check statements, all figured in. But the biggest asset of the confidence man is that his victims want to conceal their embarrassment. Thus they may pass him, unexposed and unhalted, to the next one of the gullible. The signs of fraud were everywhere in Harold Rain's actions, but hardly anyone stopped to read them."

Those who desire to "invest" in a physician, i. e., hospitals in picking interns and residents, doctors wanting associates, industries seeking medical personnel, medical societies in acting on applications for membership—even John Q. Public who wants medical services—would do well to follow the Better Business Bureau slogan of investigating before investing.

True, the Rain case is so amazing that it is almost unbelievable. Nevertheless, it did happen. It could be duplicated unless the warnings found in the Rain case are heeded.

FRINGE BENEFITS AND THE HIGH COST OF LIVING

In a recent publication of the U. S. Chamber of Commerce will be found one of the answers to present high costs of living and doing business and evidence that things aren't too bad for a great many John Does and their families.

In "Fringe Benefits, 1953," based on a study of returns from 940 employers, the Chamber of Commerce found that fringe benefits cost the employer $720 per employee on the average and that the increase was $76 per employee since 1951.

Fringe benefit payments varied widely among the 940 reporting companies, ranging from less than 5 per cent to more than 55 per cent of the payroll. The average payment was found to be 19.2 per cent of the payroll, or 34.6 cents per payroll hour. The employer's share of Old-Age and Survivors Insurance, Unemployment Compensation, Workmen's Compensation, Railroad Retirement Tax, Railroad Unemployment Insurance, etc., averaged 3.2 per cent of payrolls.

Obligations for pension premiums or payments, life insurance, hospitalization plans, surgical plans, medical care plans, death benefits, and the like cost employers an average of 5.9 per cent of payrolls. Payments for time not worked, such as paid rest periods, lunch periods, wash-up time, paid vacations, paid holidays, paid sick leave, and payments for jury duty and National Guard service averaged 8.2 per cent of payrolls. And profit sharing payments, Christmas bonuses, suggestion awards, and other awards and bonuses averaged 1.9 per cent of payrolls.

RIGHT DOWN OUR ALLEY

Right down our alley was the editorial which appeared in *The Journal of the A.M.A.* of April 24 pointing out that improving the health of a community can only result from united community action. For quite some time we have been urging the formation of Community Health Councils in all areas. The following excerpts from the A. M. A. editorial emphasizes the need for such organizations:

"To attempt to set a goal for community health without understanding the behavior patterns of the groups involved is to be unrealistic.

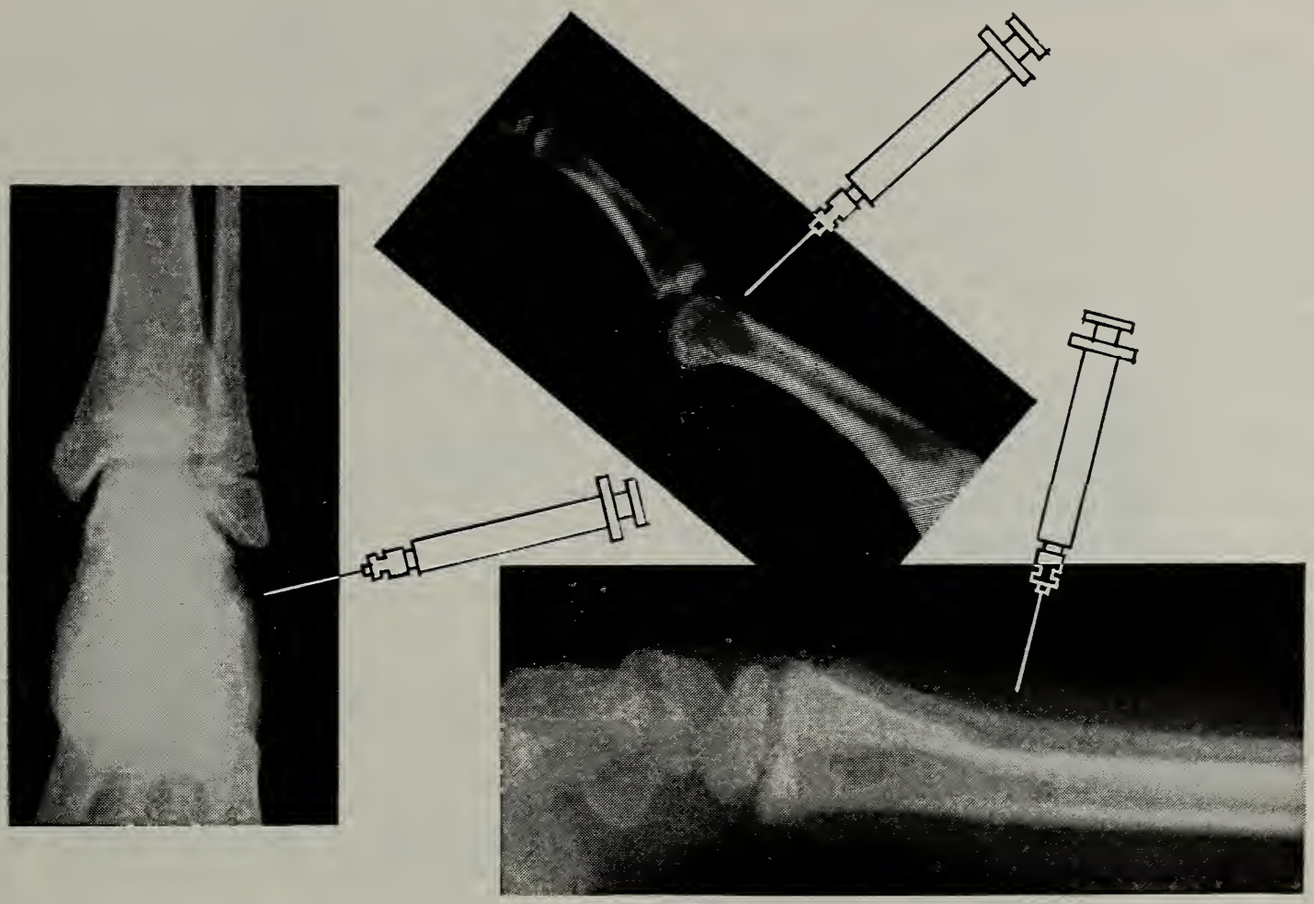
"Efforts at health education centered in schools or industrial plants may be useful, but only when they send a person back to his family prepared to adjust differences in concepts of the requirements for health and to be a health organizer in his family .

"Public health is not found in the health department but in the mental attitudes, customs, and sets of values of the people. People need to be concerned rather with their community as a whole than with public health.

"No community is perfect with regard to its health, and none is completely negligent of it, but each community's reaction to its health needs is varied and variable. It is less important to know how good the health of a community is than to know why it is at its present level.

"A community's reaction to its own level of health depends on (1) its concept of the importance of health in relation to other values, (3) the extent of effective communication between public health personnel and the section of the community they wish to reach, (4) how realistic the health plans are, and (5) the extent of participation of private (as distinct from governmental) health agencies, because the former can work with a freer hand.

"Health is not to be found apart from the general welfare of the individual or the community."



Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

In traumatic surgery[1] where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means[1, 2] of accelerating dispersion of accumulated fluids.

Swenson[2] has described his highly successful results with Alidase in various types of closed wounds. He summarized them as follows:

To remove local fluid accumulations in contusions or bruises, "The usual dose, 500 viscosity units Alidase® mixed in a small amount of normal saline, is injected into the localized fluid. Mixing the hyaluronidase in 1 per cent procaine solution will also produce local vasodilatation, relief of local pain and more rapid absorption of the fluid mass. This method can also be applied to traumatized bursae or synovial spaces which do not respond to repeated aspirations."

The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anesthesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

Fluids administered with Alidase are rapidly absorbed from subcutaneous tissue. The simplicity of hypodermoclysis avoids the cumbersome arm board, permits convenient administration with little or no pain or swelling, is vein-sparing and saves nursing time in such conditions as burns, postoperative states, toxemias and parenteral alimentation.

Alidase (brand of hyaluronidase) is supplied in serum-type ampuls of 500 viscosity units. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, J. Bone & Joint Surg. *35-A*:604 (July) 1953.
2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, Am. J. Surg. *87*:384 (March) 1954.

In Memoriam . . .

Nicola Cerri, M. D., Geauga Lake; medical degree from Regia University, Rome, Italy, 1898; aged 79; died November 4; former member of the Ohio State Medical Association, last in 1920. Dr. Cerri relinquished his medical practice in 1907 to devote time to consular work for the Italian government. He gave up those duties in 1926 in protest against the Facist regime, and resumed his practice. In 1937 he was appointed by the President as commissioner general of the Great Lakes Exposition. A son survives.

Ralph R. DuCasse, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1909; aged 67; died October 30; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Dermatology and Syphilology. Dr. DuCasse practiced for 45 years in Cincinnati, serving on the staffs of General, Good Samaritan, Speers, and St. Elizabeth Hospitals. He was a member of the Catholic Church. Surviving are his widow, a daughter and a son.

G. Glenn Frost, M. D., East Cleveland; Cleveland University of Medicine and Surgery, 1892; aged 93; died October 23. Dr. Frost practiced for more than 60 years in the Cleveland area, being in semiretirement the past 10 years. Survivors include his widow, a son and his son-in-law and daughter, Dr. and Mrs. Edward Parsons, of Shaker Heights.

Verl Z. Garster, M. D., Waynesburg; Ohio State University College of Medicine, 1921; aged 60; died October 12; member of the Ohio State Medical Association and the American Medical Association; chairman of the public relations committee of the Ohio Academy of General Practice. Dr. Garster moved to Waynesburg upon completion of his internship and had practiced there since. He was a past-president of the Rotary Club, a member of several Masonic bodies and a member of the Elks Lodge. Surviving are his widow, a son, a sister and a brother, Dr. Richard L. Garster, of Upper Sandusky.

Clarence D. Kurtz, M. D., New Philadelphia; Starling Medical School, Columbus, 1891; aged 84; died November 8; member of the Ohio State Medical Association through 1950. Dr. Kurtz had been a practicing physician for approximately 63 years, about 50 of them in Cambridge. He was a recipient of the Ohio State Medical Association's 50-Year Pin. A son survives.

Howard Walter H. Nelles, M. D., Toledo; Rush Medical College, University of Chicago, 1900; aged 76; died October 19; member of the Ohio State Medical Association through 1952. Dr. Nelles served all of his professional career in Toledo, with time out only for graduate work in Europe and in New York. He was a recipient of the Ohio State Medical Association's 50-Year Pin. He was a member of the Presbyterian Church, Rotary Club, Tile Club, Hermits and the Toledo Country Club. Surviving are his widow, a son, three daughters, and two brothers.

John M. Nowland, M. D., Capt., Army M. C.; formerly of Springfield; Ohio State University College of Medicine, 1952; aged 29; died October 7. Captain Nowland accepted a commission in the Army Medical Corps upon completion of his college training. He was serving at General Brooks Hospital, San Antonio, Texas, at the time of death. Survivors include his widow, three children, his parents and a brother.

James C. Sargent, M. D., Milwaukee, Wisc.; Ohio State University College of Medicine, 1915; aged 62; died October 7; member and past-president of the Wisconsin State Medical Society; member of the American Medical Association, the American Urological Association, American College of Surgeons, and diplomate of the American Board of Urology; Dr. Sargent was nationally known for his work with the American Medical Association. He was chairman of the A. M. A. Council on National Defense since 1947, and had been a member of that council since it was organized in 1945 as the Committee on National Emergency Medical Service. He also served as vice-chairman of the Health Resources Advisory Committee of the Office of Defense Mobilization. He was clinical professor and director of the Division of Urology, Marquette University School of Medicine. Dr. Sargent was born in Piqua, Ohio, and received his premedical education at Denison University, Granville.

George J. Searle, Sr., M. D., Bradenton, Fla.; Boston University School of Medicine, 1888; aged 92; died October 19. Dr. Searle began his practice in Massachusetts, but came to Ohio and opened a practice in Plymouth, in Richland County, in 1899. He was the first health officer of Richland County. Dr. and Mrs. Searle celebrated their Golden Wedding anniversary in Plymouth only last June. They had returned to their winter home in Florida only recently. In addition to his widow, Dr. Searle is survived by a daughter and a son, Dr. George J. Searle, Jr., of Mansfield.

Gustin C. Ullery, M. D., Springfield; State College of Physicians and Surgeons, Indianapolis, Ind., 1907; aged 74; died October 30; member of the Ohio State Medical Association; member of the American Medical Association; diplomate of the American Board of Surgery; vice-president

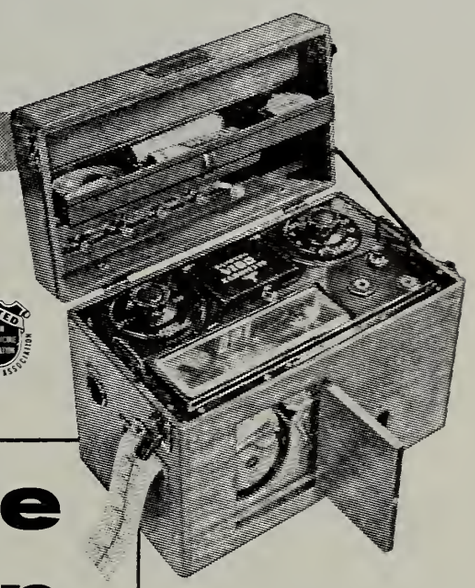
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of the Miami County Medical Society in 1921. Dr. Ullery practiced for 18 years in West Milton before he moved to Springfield in 1925. He was a member of the Methodist Church and several Masonic bodies and took a leading part in many health, civic and fraternal activities. His widow and a daughter survive.

Harvey E. Yoder, M. D., Cleveland; Western Reserve University School of Medicine, 1904; aged 77; died November 8; member of the Ohio State Medical Association through 1946; Dr. Yoder had been a practicing physician for 50 years and served all of his career in the west side area of Cleveland. He was a member of the Evangelical Lutheran Church. Survivors include his widow, two daughters, a brother and a sister.

Time Limit Is Put on Provisional Accreditation of Hospitals

The Joint Commission on Accreditation of Hospitals has voted to put a limit on the time a hospital will be permitted to hold the provisionally accredited rating.

Under a regulation adopted at a recent meeting of the Joint Commission, a provisionally accredited hospital, which remains provisionally accredited at the second survey, will be surveyed again at the end of one more year. If the hospital has not lifted itself into full accreditation status, it will be dropped into the "no accreditation" category.

The commission is composed of representatives of the American Medical Association, the American Hospital Association, the American College of Surgeons and the American College of Physicians.

Heart Investigators Will Summarize Progress in Cleveland Meeting

Four cardiovascular investigators will summarize progress in their current work before members of the Scientific Council of the Cleveland Area Heart Society on December 20 at the Cleveland Clinic, beginning at 8:15 p. m.

Program chairman for the meeting is Dr. Robert Taylor of the Division of Medicine, Cleveland Clinic. A discussion period will follow each of the three presentations.

The program is as follows:

"Effect of Hypoxia on Coronary Blood Flow in Normal and Sympathectomized Dogs," Dr. Donald B. Haekel and Dr. George H. A. Clowes; discussant, Dr. Claude S. Beck.

"Relationship of Coronary Blood Flow to Myocardial Oxygen Consumption," Dr. Robert M. Berne; discussant, Dr. John W. Martin.

"Effect of Chronic Anemia on the Development of Collateral Coronary Artery Circulation," Dr. Richard Waldo Eckstein; discussant, Dr. A. Carlton Ernstene.

Association's School Health Committee Sponsors Child Safety Exhibits

As efforts continue to cut down the increasing incidence of accidents to children, the Committee on School Health of the Ohio State Medical Association sponsored educational exhibits at the annual meetings of three state-wide organizations during the month of October.

Objective of the campaign this fall was to warn parents, teachers, and others working with children, concerning the dangers of household chemicals, pesticides, drugs and botanicals.

An extensive exhibit on "Accidental Poisoning in Children" was obtained from the Bureau of Exhibits of the American Medical Association to present the basic data. The exhibit had been prepared from information regarding authentic fatal accident cases.

The exhibit emphasizes the focal point of danger for accidents in the home, the yard, and in selected farm locations. Precautions to be observed to prevent accidental poisoning from drugs and botanicals, miscellaneous household chemicals and pesticides are graphically portrayed on the display panels, which cover more than 20 feet of linear space.

Distributed in connection with the exhibit were the following materials: "Accidental Poisoning in Children," by Bernard E. Conley, secretary, Committee on Pesticides, American Medical Association; "A Calendar for Home Safety," by Eileen Burke, a reprint from *Today's Health*; School Health Guides Numbers One, Two and Three, published by the O. S. M. A. Committee on School Health; "On Guard," regarding A. M. A. protection of the public against fake remedies; and "A Job for Everyone," by Hart F. Page, a reprint from the *Ohio Parent Teacher*.

The exhibit was presented at the State Meeting of Ohio Federation of Child Conservation Leagues, October 6, 7, and 8, in the Neil House, Columbus; the Annual Meeting of the Ohio Society for Crippled Children, October 9 and 10 at the Deshler-Hilton Hotel, Columbus; and at the Annual Ohio Congress of Parents and Teachers, held October 11, 12 and 13, at the Hotel Biltmore, Dayton. The exhibit was in charge of Hart F. Page, secretary to the Association's Committee on School Health.

Ft. Steuben Academy

The Fort Steuben Academy of Medicine met in Steubenville on November 9. The subject, "Recent Advances in Cardiac Surgery" was discussed by Dr. Charles P. Bailey, professor and head of the Department of Thoracic Surgery, Hahnemann Medical College, Philadelphia, and Dr. William Ford, on the staff of the College of Medicine, University of Pittsburgh.

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References: 1. Hollander, F.: Arch. Int. Med. *93:*107 (Jan.) 1954
2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Clinical Meeting A.M.A., St. Louis, December, 1953

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES T. ATKINSON, M. D., MIDDLETOWN)

ADAMS

The mid-day meeting of the Adams County Medical Society was held on October 27. Showing of movies from the American Cancer Society was a feature of the program. The Adams County Unit of the Cancer Society has sponsored showing of such movies to groups throughout the county.

A talk on obstetric problems was given by Dr. William Stoll, Chillicothe.

CLERMONT

Dr. Nathan Shapiro spoke at the November 17 meeting of the Clermont County Medical Society on "Ulcerative Colitis; Acute and Chronic."

Second District

(COUNCILOR: G. A. WOODHOUSE, M. D., PLEASANT HILL)

DARKE

Dr. Neil Perkins, Dayton, spoke on the subject, "Regional Enteritis" at the October 19 meeting of the Darke County Medical Society in Greenville.

At the November 16 meeting, Dr. H. J. Bearzy, Dayton, spoke on the subject, "Physiotherapy in Poliomyelitis."

GREENE

At the October meeting of the Greene County Medical Society members voted to appoint Dr. John Brown, Dayton, as clinician for the Cancer Clinic for this year. The action was on recommendation of the Cancer Committee.

The Society also voted into membership Dr. Reid P. Joyce and Dr. Juozas Kriscanciunas.

The scientific portion of the meeting was on the subject, "Diagnosis and Treatment of Back Conditions," with Dr. Rounds as speaker.

MIAMI

"The Principles of Medical Ethics" was discussed by Dr. George Woodhouse, Councilor of the Second District, at the November 12 meeting of the Miami County Medical Society in the Dettmer Hospital. Dr. Woodhouse is a member of the Judicial Council of the American Medical Association.

MONTGOMERY

Dr. Allan M. Butler, professor of pediatrics at Harvard Medical School, was guest speaker at the November 5 dinner meeting of the Montgomery County Medical Society in the Van Cleve Hotel, Dayton. His subject was "Progress in Parenteral Fluid Therapy."

A meeting on cancer, sponsored by the County Society and the County Cancer Control Society was held on November 10 in Dayton. The program consisted of three lectures and four panel discussions from which each physician could choose the one he wished to attend.

Dr. Robert Wall, assistant professor of medicine, Ohio State University, spoke on "Diagnosis and Treatment of Hodgkin's Disease."

Dr. Arthur James, associate professor of surgery, O. S. U., had as his subject "Management of Neoplasms of the Head and Neck."

The panels were as follows:

Panel A—"Carcinoma in Situ of the Cervix"; Dr. Roger Scott, moderator; Dr. P. K. Champion, Dr. George A. Nicoll and Dr. N. J. Thompson.

Panel B—"Breast Tumors"; Dr. James, moderator; Dr. W. S. Koller, Dr. Charles G. Lovingood and Dr. Frank L. Shively, Jr.

Panel C—"Lymphoma; Dr. Wall, moderator; Dr. Harry E. King, Dr. James G. Tye and Dr. Joseph M. Wilson.

Panel D—"Uterine Cancer," a film.

Dr. Roger Scott, associate professor of gynecology, Western Reserve University, gave an

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after-dinner talk on the subject, "Newer Aspects of Treatment in Gynecologic Cancer."

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

A recognition dinner for three Allen County physicians who have been in the practice of medicine for 50 years was given by the Academy of Medicine of Lima and Allen County on November 16 at the Shawnee Country Club.

The physicians are Dr. James B. Poling, Lima; Dr. Oral S. Robuck, Gomer, and Dr. Richard D. Doughty, Spencerville. Fifty-Year Pins of the Ohio State Medical Association were presented by Dr. J. R. Jarvis, Van Wert, Councilor of the Third District, representing the Association.

The scientific program speaker for the occasion was Dr. Arthur Curtis, professor of dermatology, University of Michigan, whose subject was "New Concepts of Pigmentation and the Use of Pigmenting and Depigmenting Agents."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The October program of the Academy of Medicine of Toledo anad Lucas County contained the following features:

General Meeting, October 1—"Policies and Operations," Mr. James Smith, executive director of Hospital Service Association.

"The Medical Advisory Committee—Its Purposes, Formation and Operation," Dr. A. A. Brindley.

Section on Pathology, October 8—"The Effects on Dogs of Repeated Irradiation with Small Doses of X-Ray," Dr. Hans van Baaren, Pathology Department, Flower Hospital.

Postgraduate Series, October 14-15—Dr. William A. Sodeman, University of Missouri.

Surgical Section, October 22—"Status of the Anesthetists in Great Britain," Dr. Victor Goldman, London, England.

Specialties Section, October 29—"Light-Sensitive Dermatosis Including Porphyria," Dr. Louis A. Brunsting, Mayo Clinic, Rochester, Minn.

PUTNAM

The Putnam County Medical Society held its monthly meeting at the Dumont Hotel, Ottawa, on October 5. Guest speaker was Dr. A. J. Gavigan, Lima, whose subject was "Treatment of Anxiety States."—H. N. Trumbull, M. D., Correspondent.

Fifth District

(COUNCILOR: CHARLES L. HUDSON, M. D., CLEVELAND)

LAKE

"You and Your Public" was the subject discussed by George H. Saville, Director of Public

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES, SPRING 1955

SURGERY—Surgical Technic, two weeks, Nov. 29, 1954, Jan. 24. Surgical Technic, Surgical Anatomy & Clinical Surgery, four weeks, March 7. Surgical Anatomy & Clinical Surgery, two weeks, March 21. Surgery of Colon & Rectum, one week, Nov. 29, 1954. Basic Principles in General Surgery, two weeks, March 28. General Surgery, two weeks, Dec. 6, 1954; one week, Feb. 14. Gallbladder Surgery, ten hours, April 11. Fractures & Traumatic Surgery, two weeks, March 14.

GYNECOLOGY—Office & Operative Gynecology, two weeks, Feb. 14. Vaginal Approach to Pelvic Surgery, one week, Feb. 7.

OBSTETRICS—General & Surgical Obstetrics, two weeks, Feb. 28.

MEDICINE—Two Week Course May 2. Electrocardiography & Heart Disease, two weeks, March 14. Gastroenterology, two weeks, May 16. Gastroscopy, two weeks, March 21.

RADIOLOGY—Diagnostic Course, two weeks, Jan. 3. Clinical Uses of Radio Isotopes, two weeks, April 25.

PEDIATRICS—Intensive Course, two weeks, April 4. Clinical Course, two weeks, by appointment. Cerebral Palsy, two weeks, June 13.

UROLOGY—Two-Week Urology Course, April 18. Ten-Day Practical Course in Cystoscopy every two weeks.

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Relations, Ohio State Medical Association, at the annual dinner meeting for members of the Lake County Medical Society and their wives, November 9, at Painesville. Dr. Charles L. Hudson, Cleveland, Fifth District Councilor, also attended the meeting.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

"Cancer Project in Youngstown" was the theme of the October 19 meeting of the Mahoning County Medical Society. The following topics and speakers were featured:

"The Application of Radio Isotopes in the Diagnosis and Treatment of Malignant Diseases," Dr. R. J. Scheetz;

"Differential Optical Density of Serum by Cancer and Non-Cancer Patients," Dr. A. J. Quinn;

"The Scope of the Cancer Problem at Youngstown Hospitals," Dr. A. E. Rappoport.

STARK

The subject, "Etiology and Treatment of Patients with Cough and Dyspnea of a Bronchial Pulmonary Origin," was discussed at the November 11 meeting of the Stark County Medical Society in Canton. The speakers were Dr. Earle B. Kay, St. Luke's Hospital and St. Vincent's Hospital, Cleveland; and Dr. George Wright, director of medical research at St. Luke's Hospital.

SUMMIT

Dr. James L. Doenges, president-elect of the Association of American Physicians and Surgeons, was guest speaker at the November 2 dinner meeting of the Summit County Medical Society at the Akron City Club. He spoke on the subject, "Can the Trend Toward Statism Be Reversed?"

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

A dinner meeting of the Belmont County Medical Society and Auxiliary was held at the Belmont Hills Country Club on November 18. Speaker was Dr. Arthur E. Rappoport, Youngstown Hospital Association, whose subject was "Tumor Registry."

TUSCARAWAS

Twenty-four members of the Tuscarawas County Medical Society were present at the October 14 meeting to hear Dr. Robert M. Foster, of Youngstown, give an instructive and interesting paper on "Problems of Trauma." The mate-

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rial of his paper was limited to the subject of fractures.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

Dr. L. R. Chaboudy spoke on the subject, "Modern Concepts of Carcinoma in Situ of the Cervix," at the November 8 meeting of the Scioto County Medical Society at the Portsmouth General Hospital auditorium.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

KNOX

Dr. J. M. Pumphrey, Mt. Vernon, was presented the 50-Year Pin of the Ohio State Medical Association at a staff meeting of Mercy Hospital on October 27. A native of Knox County, Dr. Pumphrey was graduated from Jefferson Medical School, Philadelphia, in 1904, and interned at Passavant Hospital, Pittsburgh. He practiced in Akron from 1905 to 1913, then after graduate study moved to Mount Vernon.

ROSS

Twenty-nine members and associates were present for the November 4 meeting of the Ross County Academy of Medicine in Chillicothe. The nominating committee submitted a slate of officers and board members to be voted on at the December meeting.

Dr. Cutlip introduced Dr. Richard Fulton who gave an interesting discussion on collagen diseases.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

ERIE

The Sandusky Register-Star-News carried a statement of the county medical society which began as follows: "Members of the Erie County Medical Society unanimously salute the recent presidential proclamation of a National Nurse Week designated for October 11 through 16.

"Authorized by Rep. Frances Bolton and signed by President Eisenhower, the resolution is designed to shift public information emphasis in nursing from the shortage of nurses to the positive service provided by nursing personnel . . ."

The resolution continues by going more into detail on the subject.

LORAIN

The regular monthly meeting of the Lorain County Medical Society was held on November 9 at the Spring Valley Country Club, Elyria, with a dinner preceding the program. After a short business meeting, a report was given by Dr. George R. Wiseman, Amherst, on the Third International Medical Congress on Internal Medicine.

RICHLAND

Approximately 45 members of the Richland County Medical Society met at the Mansfield General Hospital on September 16. Dinner was served, after which Dr. Russell H. Barnes, president, presided over a business meeting. The program was presented by Dr. Jack A. Pritchard, of University Hospitals, Cleveland. His subject was "Those Syndromes Causing Fibrinogen Depletion in Pregnancy."

Approximately 50 members of the Society met at Mansfield General Hospital on October 21. Dinner was served at the hospital, after which a business meeting was conducted by the president.

The program was presented by Dr. H. William Clatworthy, Jr., Children's Hospital, Columbus. Dr. Clatworthy gave an excellent talk on "Surgical Emergencies in the Newborn."—P. O. Staker, M. D., Secretary.

Wapakoneta—Dr. Roy C. Hunter has resigned as Auglaize County health commissioner after serving in that office for 30 years.

Youngstown—Dr. David S. Leighninger, Cleveland, discussed progress in the treatment of heart disease before the men's group of the Westminster Presbyterian Church.



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Activities of Woman's Auxiliary . . .

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President-Elect—Mrs. Karl Ritter, 1420 Shawnee Rd., Lima, Ohio

Vice-President—Mrs. Charles Obert, 20710 Park Cliff Drive, Fairview Park, Cleveland 26, Ohio

Recording Secretary—Mrs. S. L. Meltzer, 2442 Dorman Dr., Portsmouth, Ohio

Corresponding Secretary—Mrs. John Dickie, 2146 Shenandoah Rd., Toledo, Ohio

Treasurer—Mrs. Herbert Van Epps, 435 E. 15th St., Dover, Ohio

Past President—Mrs. N. M. Reiff, 404 Rawlings St., Washington Court House, Ohio

ALLEN

The Auxiliary to Lima and Allen County Academy of Medicine held its first fall meeting at the home of Mrs. R. C. Netherton, 1632 W. Market St. Assistant hostesses were Mrs. S. J. Novello and Mrs. D. W. English. Pictures of Mexico were shown by Mrs. A. A. Dalton.

Members of the Auxiliary were hostesses on October 26 to the various auxiliaries in the Third District. Miss Genevieve Dolkan, R. N., Toledo, president of the Ohio League for Nursing, was the speaker. Mrs. J. M. McBride, Lima, is director of the district which comprises 11 counties. Mrs. Karl Ritter, a member of the local group, is president-elect of the Ohio Auxiliary.

The group's seven yearly projects are: Maintaining a loan scholarship fund for student nurses; making washable slippers for St. Rita's, Memorial, the District Tuberculosis and Bluffton Community Hospitals; assisting the Y. W. C. A.'s Best Years Club; following activities of the Mental Hygiene Association, Child Guidance Center and Allen County Health Council; nurse recruitment; and cooperating with the Lima Public Library in distributing books at St. Rita's Hospital each week.

In January the group will meet at the home of Mrs. Becker to make slippers for the hospitals. A guest luncheon is planned for February 22 with Dr. R. E. Bushong, superintendent of the Lima State Hospital as speaker. Nurse recruitment will be featured on March 26 when the Auxiliary will entertain ninth graders of Lima and Allen County schools at teas to be held in both Memorial and St. Rita's hospitals. In April members will give a dance at Shawnee Country Club. A covered dish luncheon in the home of Mrs. H. L. Stelzer May 24 will mark the close of the season's activities. Program will feature a "Legislation Roundup" by Mrs. W. B. Light and Mrs. R. L. Techlenberg.

COSHOCTON

The Coshocton Auxiliary entertained the Seventh District at a luncheon at the Coshocton Town and Country Club on October 15. State officers present were Mrs. A. Paul Hancuff, Mrs. Herbert Van Epps. An interesting and informative talk was given by the State President, Mrs. Hancuff.

ERIE

The October meeting of the Woman's Auxiliary to the Erie County Medical Society was held at the Business Women's Club. Hostesses were Mrs. S. R. Hoover, Mrs. J. P. Ohlmacher, Mrs. R. M. Knoble and Mrs. Dean Sheldon.

Talks by Mrs. F. E. Reed, Huron, on the

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"Christian Herald's Bible Land," and Attorney Kenneth Tone, representing the City Charter Committee, were program features.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society met on Tuesday, October 12, at Shades Pine Room in Canal Winchester. Mrs. W. Monger, Mrs. C. P. Swett and Mrs. A. B. VanGundy were hostesses. Members were asked to attend the Eighth District meeting scheduled at Granville Inn on October 21.

FRANKLIN

A style show and luncheon at Ilonka's Provincial House on September 20 was enjoyed by the Woman's Auxiliary to the Columbus Academy of Medicine. Arrangements for the event were made by Mrs. Charles Matthews, Mrs. O. F. Rosenow, Mrs. Arthur James, and Mrs. W. Hugh Misildine.

HAMILTON

Mrs. Robert M. Woodford, president of the Woman's Auxiliary to the Hamilton County Medical Society, presided at the opening meeting, which was held October 19 at the Losantiville Country Club. Mr. Dwight W. Hostetter, trust officer of the Central Trust Company, spoke on "Financial Prescription for a Doctor's Family."

HURON

On Friday, October 8 the Huron County Medical Auxiliary met at the home of Mrs. Robert Gill in Norwalk. After a business session the group visited the Civil Defense Headquarters where the first Rescue School in the United States was established by Mr. Lee Maloney. Mr. Maloney gave an interesting talk on the work in the various departments under Civil Defense.

LICKING

The Woman's Auxiliary to the Licking County Medical Society met at Hotel Warden to make plans for the Eighth District meeting to be held on October 21. Mrs. G. A. Gressle, director, was designated to preside.

LOGAN

High school girls interested in nursing were entertained at a Tea October 5 in the Mary Rutan Hospital. Members of the Woman's Auxiliary of the Logan County Medical Society sponsored this annual event. Mrs. Charles Thompson, president, welcomed the visitors and Mrs. Mary Jo Elswick, superintendent of nurses, gave an illustrated talk. One hundred and fifty girls from Bellefontaine and Logan County were present.

LORAIN

A very interesting meeting was held in October by the Lorain County Medical Auxiliary. Attorney James Parobec gave a talk, explaining the need for a detention home and the group voted to support it. Miss Cynthia Dauch, director of the Visiting Nurses Association, Cleveland, and Mrs. Gerald Krupp, chairman of the Lorain County Visiting Nurses, were guest speakers and gave the members needed information.

Mr. Blake Crider, director of the psychology department of Fenn College, will address the group November 18 at the Spring Valley Country Club.

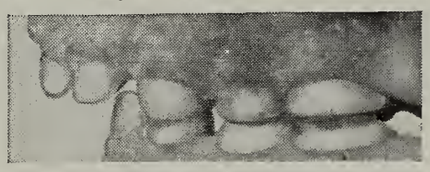
LUCAS

Mrs. John D. Dickie, chairman, and Mrs. M. M. Thompson, Jr., entertained the social committee of the Auxiliary to the Academy of Medicine of Toledo and Lucas County, September 14, at a tea in the Academy Bldg. Plans were made for the year's social activities.

The evening unit of the Live Issues of Today study group met October 1 in the home of Mrs. J. W. Millis, 2509 Meadowwood Drive. Political

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issues were discussed and Mrs. George Boyden spoke on "Japan Today."

The Live Issues afternoon group met at the home of Mrs. Hazen Hauman, 4201 River Road. Mrs. Carl Dreyer was co-chairman. A discussion on political issues, with emphasis on the November election, was led by Mrs. Bernard Steinberg.

Mrs. William Phillips was hostess to the first meeting of the Child Development Group at her home 3303 Gallatin Rd., October 8. Miss Flora Lee Sherman was discussion leader.

The English study group met at the Academy of Medicine Bldg. with Mrs. Paul Hohly as chairman. Mrs. Charles Bayer and Mrs. Ned Hein were co-chairmen.

The Musical Masqueraders, a choral group, planned to meet the first and third Mondays each month, beginning in November. Mrs. A. J. Kuehn was scheduled to be hostess at the first meeting.

OTTAWA

Dr. and Mrs. James I. Rhiel graciously opened their home to the Ottawa County Medical Society and the Woman's Auxiliary, October 14. The Auxiliary members held a brief business meeting. Plans for the annual rummage sale at the Guild Hall were completed. Mrs. A. D. Miessner distributed charity ball tickets. Mrs. Ley announced plans for the forthcoming benefit dance to be held November 27 at Biro Auditorium.

PICKAWAY

Mrs. Ray Carroll of Circle Drive was hostess to the Pickaway County Medical Auxiliary. The members, who also compose Berger Hospital Guild 1, completed plans for the annual General Guild bazaar, sponsored by the group. Plans were also made for nursing recruitment during the coming year. After the business session the afternoon was spent in making various items for the bazaar.

RICHLAND

Mrs. Wm. Hagen and Mrs. Lee Bernheimer were guests of the Woman's Auxiliary to the Richland County Medical Society for a luncheon on October 4th at the Woman's Club. During the business session, the members voted to appoint a representative to the Richland County Health Council and to the social study group.

Mrs. Charles Curtiss, Bellville, gave a talk and showed films taken in the Black Hills, Estes Park, Yellowstone National Park, the Rocky Mts. and Glacier and Yosemite National Parks. Hostesses for the meeting were Mrs. Carl Damron, Mrs. George Evans, Mrs. Charles Brown and Mrs. D. Peppard.

ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine met at Allyn's Dining Room on October 7. Mrs. G. Howard Wood, president, conducted the business meeting. A donation of $25 was made to the American Medical Education Foundation, and a suction pump was given to the Chillicothe Hospital.

SANDUSKY

The October meeting of the Woman's Auxiliary to the Sandusky County Medical Society met in the home of Mrs. C. I. Kuntz. Mrs. Richard Belch was welcomed as a new member. During the business meeting it was voted to give a donation to the Community Chest. Subscriptions to *Today's Health* will be given to county and local schools.

Highlight of the program was a book review

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by Mrs. A. G. Henkel on *Where Main Street Meets the River* written by Hodding Carter.

SCIOTO

The value of a good public relations program was stressed recently in an address before members of the Woman's Auxiliary to the Scioto County Medical Society. The speaker was the State President, Mrs. A. Paul Hancuff, who addressed the local group at its 14th birthday luncheon at Darrone's Restaurant, Portsmouth.

Mrs. Samuel L. Meltzer, first president of the local group, and chairman of the day's activities, paid tribute to persons representing the 12 organizations engaged in allied field of health and welfare and in which doctors' wives have participated.

Other speakers at the birthday luncheon were Mrs. Karl Ritter of Lima, state president-elect; Dr. Jackson Herbert, president of Scioto County Medical Society; and Mrs. Harry Nenni of Ironton, ninth district director. The welcome to those attending the meeting was extended by Mrs. Joseph Gohmann, president of the local Auxiliary. The program included entertainment by student nurses at Mercy Hospital.

SUMMIT

One of the first things a woman thinks about when it comes time to select a new Autumn outfit is a hat. With this in mind, the Woman's Auxiliary to the Summit County Medical Society, held a "hat show" at their annual garden party on August 19, with Mrs. J. Walter Johnson, Southwood Rd., Fairlawn Heights, as hostess. More than 450 guests attended the show. The proceeds from the party are for the revolving loan fund used to aid prospective student nurses as well as those already in training. Mrs. Arthur M. Loomis was general chairman with Mrs. Robert J. Ferras assisting.

It's fun to grow old in Akron. That fact was demonstrated at the annual Hobby Show for Oldsters, September 10 to 13. This show is sponsored by the United Community Council and the Auxiliary of the Summit County Medical Society. Long hours of planning and work went into making this project a success. Carrying the ball were committee members of the Auxiliary—Mrs. Fred Dixon, Mrs. Edwin Mollin, Mrs. Robert Williams, Mrs. Ralph Summerfield, Mrs. Walter H. Brown, and Mrs. Arthur Dobkin. This year, for the first time, music was played at intervals by groups of oldtimers. There were many unusual displays, and anyone looking for a hobby found many ideas here.

A panel patterned after television's "What's My Line?" was the feature of the October meeting at which Mrs. R. R. Pliskin served as moderator for panelists, Mrs. A. Brown, Mrs. M. E. Griffin and Mrs. William Davis.

TRUMBULL

The Trumbull County Medical Society and its Auxiliary held a joint meeting at the Warner Hotel September 15. Dr. Stanley T. Garber, professor of obstetrics at the Cincinnati College of Medicine, was the guest speaker, having as his subject, "Toxemias in Pregnancy."

The Medical Society held its business meeting while the Auxiliary had as its speaker Mrs. Karl Ritter of Lima, president-elect of the Ohio State Medical Auxiliary. Her topic was "Auxiliaries and What They Can Do."

The Medical Auxiliary in conjunction with the Trumbull County Bar Auxiliary held a joint meeting in October at the Squaw Creek Country Club. Mrs. Joseph A. Ralston introduced Mrs. Clarence Klinger as the first president of the Bar Auxiliary, explaining that it had just recently been formed and is one of the very few in the country.

The Trumbull Memorial Hospital Student Nurse Choral Group gave a number of selections. Mrs. William A. Ticknor, a board member of the League of Women Voters, explained the important issues in the November election and displayed a miniature voting machine.

VAN WERT

The October meeting of the Van Wert Medical Auxiliary was held at the home of Mrs. O. J. Fatum. This year's officers are: President, Mrs.

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R. W. Ayres; vice-president, Mrs. J. Cox; and secretary-treasurer, Mrs. H. D. Underwood.

The program for the coming year was announced. It includes speakers on local health subjects, discussions and educational motion pictures.

It Is Urgent That Data Cards Be Sent In Early for Medical Directory

The American Medical Association is now in process of making final corrections and additions to the new edition of the *American Medical Directory*, which should be ready for distribution about the middle of 1955. It is most urgent that physicians carefully fill out the information cards being sent them and return them as soon as possible to the A. M. A.

Information cards are being sent to all physicians on record with the A. M. A. The physician should send in the information regardless of whether or not he is a member of the A. M. A. or an affiliate society, since the *Directory* will include a listing of all physicians, in practice or not in practice.

For the first time special symbols will be used in the *American Medical Directory* to distinguish the various types of membership in the A. M. A.—active, associate, affiliate, honorary and service. A new symbol also designates physicians who hold membership in a constituent association but do not hold A. M. A. membership.

There is no charge made for inserting the information in the *Directory* and no obligation on the part of the physician. The card contains two sections—one section for information which will be used in the *Directory*, and one section for statistical information only.

For those physicians who wish to order the *Directory*, an order blank is being enclosed with the other material. The prepublication price is $25. After publication, the price will be $30.

The new 19th Edition will contain data on more than 240,000 physicians, including 200,000 corrections since the 1950 edition was published, and 20,000 more names. The names of 40,000 new physicians have been added to the biographical records and about 20,000 deleted because of death and other reasons.

The *Directory* also contains valuable information on hospitals and sanatoriums, medical schools, medical laws, medical journals, libraries, licensing and examining boards, specialty boards, health officers, etc.

Navy Crew Fund Goes to A. M. E. F.

The crew of a Navy supply transport vessel honored a fellow crew member lost at sea by creating a memorial fund which was turned over to the American Medical Education Foundation.

The crew of the U. S. S. Achernar (AKA-53) created the fund of $147.31 in honor of Hospital Corpsman John Phillip Blackmer, of Washington, D. C., who had hoped to become a doctor.

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Nobel Prize Awarded Dr. Robbins For Polio Virus Studies

A discovery that opened the door toward the production of polio vaccine has brought one of the highest distinctions to an Ohio physician and his two colleagues.

Dr. Frederick C. Robbins, professor of pediatrics at Western Reserve University School of Medicine, and chief of pediatrics and contagious diseases at City Hospital, Cleveland, and his former co-workers will receive the Nobel Prize for physiology and medicine, from the hands of King Gustav Adolph of Sweden in ceremonies in that country on December 10.

Dr. Robbins, with Dr. John F. Enders and Dr. Thomas H. Weller, of Harvard University, will share equally in the honor and the award of $35,066.

The team started its research project in 1948 and the next year came up with a practical method of growing polio virus in non-nervous tissue in test tubes. The research was done at Harvard. Dr. Robbins came to Western Reserve in 1952.

COMING MEETINGS

Ohio State Medical Association, 1955 Annual Meeting, week of April 18, 1955, Cincinnati.

American Medical Association, 1955 Annual Meeting, June 6-10, 1955, Atlantic City, N. J.

Cleveland Area Heart Society, Course in Resuscitation, December 17-18.

American College of Surgeons Section Meeting, Cleveland, February 21-24.

Tenth National Conference on Rural Health, Milwaukee, Wisc., February 24-26.

American College of Physicians, Philadelphia, April 25-29.

Oak Hill—Surrounding communities joined with local committees to celebrate "Dr. Allison Day" in honor of Dr. Brinton J. Allison on November 6.

Dr. James M. Knopp has been named clinical director of the new three-county Wayne-Medina-Holmes Guidance Center in Wooster. He has been serving with the Air Force.

ALEXANDER MACK, M.D.
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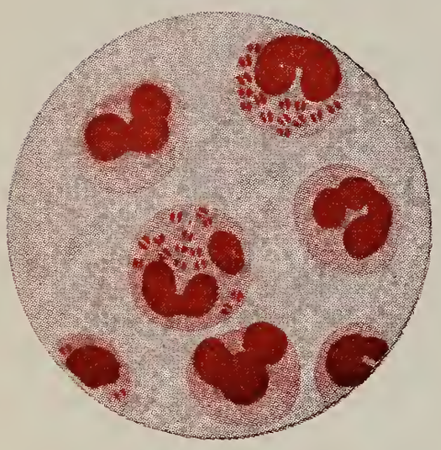
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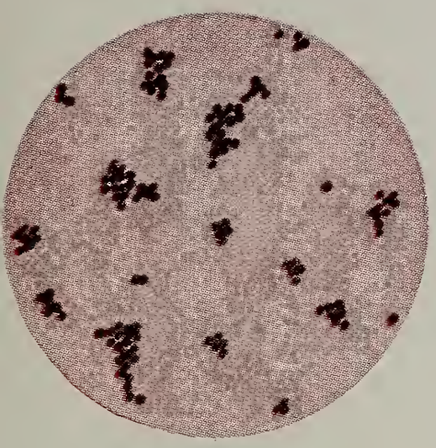


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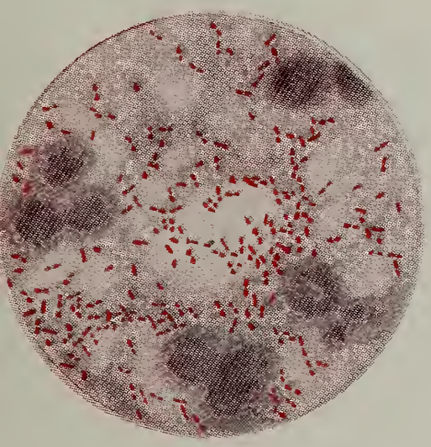
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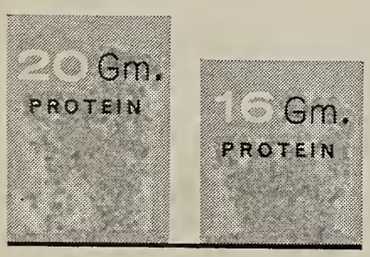


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44347

Ohio state medical journal.

AUTHOR

v.50, 1954

TITLE

Ohio state medical journal. 44347
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